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Statutes:

All laws specifically codified by the General Assembly of the State of Georgia through the 2012 Regular Session of the General Assembly.

Annotations of Judicial Decisions:

Case annotations reflecting decisions posted to LexisNexis® through March 30, 2012. These annotations will appear in the following traditional reporter sources: Georgia Reports; Georgia Appeals Reports; Southeastern Reporter; Supreme Court Reporter; Federal Reporter; Federal Supplement; Federal Rules Decisions; Lawyers' Edition; United States Reports; and Bankruptcy Reporter.

Annotations of Attorney General Opinions:

Constructions of the Official Code of Georgia Annotated, prior Codes of Georgia, Georgia Laws, the Constitution of Georgia, and the Constitution of the United States by the Attorney General of the State of Georgia posted to LexisNexis® through March 30, 2012.

Other Annotations:

References to:

Emory Bankruptcy Developments Journal.
Emory International Law Review.
Emory Law Journal.
Georgia Journal of International and Comparative Law.
Georgia Law Review.
Georgia State University Law Review.
Mercer Law Review.
Georgia State Bar Journal.
Georgia Journal of Intellectual Property Law.
American Jurisprudence, Second Edition.
American Jurisprudence, Pleading and Practice.
American Jurisprudence, Proof of Facts.
American Jurisprudence, Trials.
Corpus Juris Secundum.
Uniform Laws Annotated.
American Law Reports, First through Sixth Series.
American Law Reports, Federal.

Tables:

In Volume 41, a Table Eleven-A comparing provisions of the 1976 Constitution of Georgia to the 1983 Constitution of Georgia and a Table Eleven-B comparing provisions of the 1983 Constitution of Georgia to the 1976 Constitution of Georgia.

An updated version of Table Fifteen which reflects legislation through the 2012 Regular Session of the General Assembly.

Indices:

A cumulative replacement index to laws codified in the 2012 supplement pamphlets and in the bound volumes of the Code.

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TITLE 33

INSURANCE

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63. Guaranteed Asset Protection Waivers, 33-63-1 through 33-63-9.

64. Regulation and Licensure of Pharmacy Benefits Managers, 33-64-1 through 33-64-8.

Law reviews. — For annual survey article on insurance law, see 49 Mercer L. Rev. 175 (1997). For annual survey article discussing developments in insurance law, see 51 Mercer L. Rev. 313 (1999). For annual survey article on insurance law, see 52 Mercer L. Rev. 303 (2000).

For note, "The Parity Cure: Solving Unequal Treatment of Mental Illness Health Insurance Through Federal Legislation," see 44 Ga. L. Rev. 511 (2010). For note, "When an Idea is More Than Just an Idea: Insurance Coverage of Business Method Patent Infringement Suits Under Advertising Injury Provisions of Commercial General Liability Policies," see 18 J. Intell. Prop. L. 631 (2011).

CHAPTER 1

GENERAL PROVISIONS

33-1-1. Short title.

RESEARCH REFERENCES

Am. Jur. Pleading and Practice Forms. — 14A Am. Jur. Pleading and Practice Forms, Insurance, § 2.

33-1-2. Definitions.

As used in this title, the term:

(1) "Commissioner of Insurance" or "Commissioner" means the Commissioner of Insurance of the State of Georgia.

(1.1) "Health benefit policy," "health benefit plan," or other similar terms do not include limited benefit insurance policies designed, advertised, and marketed to supplement major medical insurance such as accident only, Champus supplement, dental, disability income, fixed indemnity, long-term care, Medicare supplement, specified disease, vision, and any other type of accident and sickness insurance other than basic hospital expense, basic medical-surgical expense, or major medical insurance.

(2) "Insurance" means a contract which is an integral part of a plan for distributing individual losses whereby one undertakes to indemnify another or to pay a specified amount or benefits upon determinable contingencies.

(3) "Insurance Department" or "department" means the Insurance Department established by Code Section 33-2-1.

(4) "Insurer" means any person engaged as indemnitor, surety, or contractor who issues insurance, annuity or endowment contracts, subscriber certificates, or other contracts of insurance by whatever name called. Hospital service nonprofit corporations, nonprofit medical service corporations, burial associations, health care plans, and health maintenance organizations are insurers within the meaning of this title.

(4.1) "Natural person" means an individual human being and does not include any firm, partnership, association, corporation, or trust.

(5) "Person" means an individual, insurer, company, association, trade association, organization, society, reciprocal or interinsurance exchange, partnership, syndicate, business trust, corporation, Lloyd's association, and associations, groups, or department of underwriters, and any other legal entity.

(5.1) "Security," "security deposit," "special deposit," or "deposit," when used to refer to posted deposits required to be placed in the

possession of the Commissioner, shall mean the actual physical evidence of a security, such as a certificate, or an entry made through the federal reserve book-entry system. The federal reserve book-entry system shall be limited in meaning to the computerized systems sponsored by the United States Department of Treasury and certain agencies and instrumentalities of the United States for holding and transferring securities of the United States government and such agencies and instrumentalities, respectively, in federal reserve banks through banks which are members of the Federal Reserve System or which otherwise have access to such computerized systems.

(6) "Transact," with respect to insurance, includes any of the following:

(A) Solicitation and inducement;

(B) Preliminary negotiations;

(C) Effectuation of a contract of insurance; or

(D) Transaction of matters subsequent to effectuation of the contract and arising out of it. (Code 1933, §§ 56-102, 56-103, 56-104, 56-105, 56-106, 56-107, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 1988, p. 693, § 1; Ga. L. 1989, p. 1119, § 1; Ga. L. 2000, p. 136, § 33; Ga. L. 2003, p. 387, § 1.1; Ga. L. 2003, p. 872, § 1.)

The 2003 amendments. — The first 2003 amendment, effective May 30, 2003, added paragraph (4.1). The second 2003 amendment, effective July 1, 2003, added paragraph (1.1).

JUDICIAL DECISIONS

Purpose, effect, contents, and import determine if contract is "insurance."

A contract to underwrite a hole-in-one give-away by indemnifying the sponsor of a golf tournament for the cost of the prize awarded for a hole-in-one on a particular hole was an "insurance" contract. Golf Mktg., Inc. v. Atlanta Classic Cars, Inc., 245 Ga. App. 720, 538 S.E.2d 809 (2000).

Period of coverage. — Mere idea of retroactive insurance coverage defied common sense; according to O.C.G.A. § 33-1-2(2), insurance was a contract which was an integral part of a plan for distributing individual losses whereby one undertook to indemnify another or to pay a specified amount or benefits upon determinable contingencies. Coverage for an event that already occurred contravened the very definition of insurance; a reasonable person speaking with any insurance agent would not reasonably believe that an insurance agent has the authority to provide retroactive coverage. Rutland v. State Farm Mut. Auto. Ins. Co., No. 10-10734, 2010 U.S. App. LEXIS 16744 (11th Cir. Aug. 12, 2010) (Unpublished).

Selling memberships in automobile clubs was "insurance." — Based on the fact that selling memberships in automobile clubs was considered "insurance" under O.C.G.A. § 33-1-2(2) and application of the Federal Arbitration Act (FAA), 9 U.S.C. §§ 1-16, would impair O.C.G.A. § 9-9-2(c)(3), the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015, preempted the FAA and prohibited enforcement of the parties' arbitration agreement. Love v.

Money Tree, Inc., 279 Ga. 476, 614 S.E.2d 47 (2005).

Arbitration agreements. — O.C.G.A. § 9-9-2(c)(3) invalidates arbitration agreements in insurance contracts as defined in O.C.G.A. § 33-1-2, with the exception that it does not prohibit enforcement of arbitration agreements in contracts between insurance companies; simply stated, in Georgia a contract of insurance is not subject to arbitration unless the contract is between insurance companies. Davis v. Zurich Am. Ins. Co. (In re TFI Enters.), No. 05-40683 RFH, 2008 Bankr. LEXIS 1059 (Bankr. M.D. Ga. Apr. 9, 2008).

Employee had no authority to offer retroactive coverage. — When an insured was in a car crash after an insurer canceled the policy for failing to pay the premium and an insurance employee allegedly told the insured that the insurer would provide retroactive coverage for the crash if the insured paid the past-due amount, the insurer had no duty to defend the insured because, inter alia, the insurance employee did not have the actual or apparent authority to bind the insurer to retroactive coverage of the crash. Rutland v. State Farm Mut. Auto. Ins. Co., No. 10-10734, 2011 U.S. App. LEXIS 9859 (11th Cir. May 12, 2011) (Unpublished).

33-1-9. Insurance fraud; venue; penalty; exemption.

(a) Any natural person who knowingly or willfully:

(1) Makes or aids in the making of any false or fraudulent statement or representation of any material fact or thing:

(A) In any written statement or certificate;

(B) In the filing of a claim;

(C) In the making of an application for a policy of insurance;

(D) In the receiving of such an application for a policy of insurance; or

(E) In the receiving of money for such application for a policy of insurance

for the purpose of procuring or attempting to procure the payment of any false or fraudulent claim or other benefit by an insurer;

(2) Receives money for the purpose of purchasing insurance and converts such money to such person's own benefit;

(3) Issues fake or counterfeit insurance policies, certificates of insurance, insurance identification cards, or insurance binders; or

(4) Makes any false or fraudulent representation as to the death or disability of a policy or certificate holder in any written statement or certificate for the purpose of fraudulently obtaining money or benefit from an insurer

commits the crime of insurance fraud.

(b) Any natural person who knowingly and willfully or with reckless disregard engages in the following activities, either directly or indirectly, as an agent for, as a representative of, or on behalf of an insurer

not authorized to transact insurance in this state commits the crime of insurance fraud:

(1) Soliciting, negotiating, procuring, or effectuating insurance or annuity contracts or renewals thereof;

(2) Soliciting, negotiating, procuring, or effectuating any contract relating to benefits or services;

(3) Disseminating information as to coverage or rates;

(4) Forwarding applications;

(5) Delivering policies or contracts;

(6) Inspecting or assessing risk;

(7) Fixing of rates;

(8) Investigating or adjusting claims or losses;

(9) Collecting or forwarding of premiums; or

(10) In any other manner representing or assisting such an insurer in the transaction of insurance with respect to subjects of insurance resident, located, or to be performed in this state.

(c) Any natural person who knowingly and willfully with intent to defraud subscribes, makes, or concurs in making any annual or other statement required by law to be filed with the Commissioner containing any material statement which is false commits the crime of insurance fraud.

(d) In any prosecution under this Code section, the crime shall be considered as having been committed in the county of the purported loss, in the county in which the insurer or the insurer's agent received the fraudulent or false claim or application, in the county in which money was received for the fraudulent application, or in any county where any act in furtherance of the criminal scheme was committed.

(e) A natural person convicted of a violation of this Code section shall be guilty of a felony and shall be punished by imprisonment for not less than two nor more than ten years, or by a fine of not more than $10,000.00, or both.

(f) Subsection (b) of this Code section shall not apply to a contract of insurance entered into in accordance with Article 2 of Chapter 5 of this title. (Code 1933, § 56-9910, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1985, p. 723, § 1; Ga. L. 1991, p. 1608, § 1.1; Ga. L. 1997, p. 1296, § 1; Ga. L. 1998, p. 1064, § 1; Ga. L. 2003, p. 387, § 1.2; Ga. L. 2003, p. 641, § 1; Ga. L. 2004, p. 754, § 1A.)

The 2003 amendments. — The first 2003 amendment, effective May 30, 2003, inserted "natural" near the beginning of subsection (c). The second 2003 amendment, effective June 3, 2003, added subsections (b) and (c), redesignated former subsections (b) and (c) as present subsections (d) and (e), respectively, and added subsection (f).

The 2004 amendment, effective May 13, 2004, deleted "subsection (a) of" preceding "this Code section" near the beginning of subsection (e).

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2003, "Commissioner" was substituted for "commission" in subsection (c).

JUDICIAL DECISIONS

Venue for staged accidents. — Because a staged wreck was clearly an act in furtherance of a criminal scheme, venue was proper in the county where the wreck occurred. Callaway v. State, 247 Ga. App. 310, 542 S.E.2d 596 (2000).

Evidence sufficient for conviction. — Callaway v. State, 247 Ga. App. 310, 542 S.E.2d 596 (2000).

Cited in Summit Auto. Group, LLC v. Clark Kia Motors Ame., Inc., 298 Ga. App. 875, 681 S.E.2d 681 (2009).

33-1-16. Investigation of fraudulent insurance act; collection of evidence; immunity from liability; public inspection; enforcement.

JUDICIAL DECISIONS

Cited in Nat'l Viatical, Inc. v. State, 258 Ga. App. 408, 574 S.E.2d 337 (2002).

33-1-18. Housing tax credit for qualified projects; rules and regulations.

(a) As used in this Code section, the term:

(1) "Federal housing tax credit" means the federal tax credit as provided in Section 42 of the Internal Revenue Code of 1986, as amended.

(2) "Median income" means those incomes that are determined by the federal Department of Housing and Urban Development guidelines and adjusted for family size.

(3) "Project" means a housing project that has restricted rents that do not exceed 30 percent of median income for at least 40 percent of its units occupied by persons or families having incomes of 60 percent or less of the median income or at least 20 percent of the units occupied by persons or families having incomes of 50 percent or less of the median income.

(4) "Qualified basis" means that portion of the tax basis of a qualified Georgia project eligible for the federal housing tax credit, as that term is defined in Section 42 of the Internal Revenue Code of 1986, as amended.

(5) "Qualified Georgia project" means a qualified low-income building as that term is defined in Section 42 of the Internal Revenue Code of 1986, as amended, that is located in Georgia.

(b)(1) A tax credit against the taxes imposed under Code Sections 33-5-31, 33-8-4, and 33-40-5, to be termed the Georgia housing tax credit, shall be allowed with respect to each qualified Georgia project placed in service after January 1, 2001. The amount of such credit shall, when combined with the total amount of credit authorized under Code Section 48-7-29.6, in no event exceed an amount equal to the federal housing tax credit allowed with respect to such qualified Georgia project.

(2)(A) If under Section 42 of the Internal Revenue Code of 1986, as amended, a portion of any federal housing tax credit taken on a project is required to be recaptured as a result of a reduction in the qualified basis of such project, the taxpayer claiming any state tax credit with respect to such project shall also be required to recapture a portion of any state tax credit authorized by this Code section. The state recapture amount shall be equal to the proportion of the state tax credit claimed by the taxpayer that equals the proportion the federal recapture amount bears to the original federal housing tax credit amount subject to recapture. The tax credit under this Code section shall not be subject to recapture if such recapture is due solely to the sale or transfer of any direct or indirect interest in such qualified Georgia project.

(B) In the event that recapture of any Georgia housing tax credit is required, any amended return submitted to the Commissioner as provided in this Code section shall include the proportion of the state tax credit required to be recaptured, the identity of each taxpayer subject to the recapture, and the amount of tax credit previously allocated to such taxpayer.

(3) In no event shall the total amount of the tax credit under this Code section for a taxable year exceed the taxpayer's tax liability under Code Sections 33-5-31, 33-8-4, and 33-40-5. Any unused tax credit shall be allowed to be carried forward to apply to the taxpayer's next three succeeding years' tax liability. No such tax credit shall be allowed the taxpayer against prior years' tax liability.

(4) The tax credit allowed under this Code section, and any recaptured tax credit, shall be allocated among some or all of the partners, members, or shareholders of the entity owning the project in any manner agreed to by such persons, whether or not such persons are allocated or allowed any portion of the federal housing tax credit with respect to the project.

(c) The commissioner and the state department designated by the Governor as the state housing credit agency for purposes of Section

42(h) of the Internal Revenue Code of 1986, as amended, shall each be authorized to promulgate any rules and regulations necessary to implement and administer this Code section. (Code 1981, § 33-1-18, enacted by Ga. L. 2001, p. 1181, § 2; Ga. L. 2002, p. 415, § 33; Ga. L. 2003, p. 640, § 1.)

Effective date. — This Code section became effective January 1, 2002.

The 2002 amendment, effective April 18, 2002, part of an Act to revise, modernize, and correct the Code, revised punctuation in paragraph (a)(3).

The 2003 amendment, effective June 3, 2003, substituted "tax liability under Code Sections 33-5-31, 33-8-4, and 33-40-5" for "income tax liability" at the end of first sentence in paragraph (b)(3).

Editor's notes. — Ga. L. 2001, p. 1181, § 3, not codified by the General Assembly, provides that this Code section shall be applicable to all taxable years beginning on or after January 1, 2002.

U.S. Code. — Section 42 of the Internal Revenue Code of 1986, referred to in this Code section, is codified as 26 U.S.C. § 42.

Law reviews. — For article, "Revenue and Taxation: Amend Titles 48, 2, 28, 33, 36, 46, and 50 of the Official Code of Georgia Annotated, Relating Respectively to Revenue and Taxation, Agriculture, the General Assembly, Insurance, Local Government, Public Utilities, and State Government," see 28 Ga. St. U. L. Rev. 217 (2011).

33-1-19. Special Advisory Commission on Mandated Health Insurance Benefits.

(a) The Special Advisory Commission on Mandated Health Insurance Benefits is hereby established, effective February 1, 2012, to advise the Governor and the General Assembly on the social and financial impact of current and proposed mandated benefits and providers, in the manner set forth in this Code section. The advisory commission shall be composed of 20 members and three ex officio members. Sixteen members shall be appointed by the Governor on or after February 1, 2012, as follows: one dentist, one obstetrician, one pediatrician, one family practice physician, one physician who is a specialist in chronic disease, one chief medical officer of a general, acute care hospital, one allied health professional, two representatives of small business, two representatives of a major industry, one expert in the field of medical ethics, one representative of the accident and health insurance industry, one representative from the Georgia Association of Health Plans, and two citizen members. The Senate Committee on Assignments shall appoint one member from the Senate Health and Human Services Committee and one member from the Senate Insurance and Labor Committee, and the Speaker of the House of Representatives shall appoint one member from the House Committee on Health and Human Services and one member from the House Committee on Insurance. The commissioner of community health, the Commissioner of Labor, and the Commissioner of Insurance shall serve as ex officio, nonvoting members. All members shall be appointed for terms of four years each, except that appointments to fill vacancies shall be made for the unexpired terms.

(b) No person shall be eligible to serve for or during more than two successive four-year terms; but after the expiration of a term of two years or less, or after the expiration of the remainder of a term to which appointed to fill a vacancy, two additional four-year terms may be served by such a member if so appointed.

(c) The advisory commission shall meet regularly and at the request of the Governor. The first meeting of the advisory commission shall be held no later than March 1, 2012, at which time the advisory commission shall select a chairperson and a vice chairperson, as determined by the membership.

(d) The advisory commission shall:

(1) Develop and maintain, with the Insurance Department, a system and program of data collection to assess the impact of mandated benefits and providers, including costs to employers and insurers, impact of treatment, cost savings in the health care system, number of providers, and other data as may be appropriate;

(2) Advise and assist the Insurance Department on matters relating to mandated insurance benefits and provider regulations;

(3) Prescribe the format, content, and timing of information to be submitted to the advisory commission in its assessment of proposed and existing mandated benefits and providers. Such format, content, and timing requirements shall be binding upon all parties submitting information to the advisory commission in its assessment of proposed and existing mandated benefits and providers;

(4) Provide assessments of proposed and existing mandated benefits and providers and other studies of mandated benefits and provider issues as requested by the General Assembly;

(5) Provide additional information and recommendations, relating to any system of mandated health insurance benefits and providers, to the Governor and the General Assembly, upon request; and

(6) Report annually on its activities to the joint standing committees of the General Assembly having jurisdiction over insurance by December 1 of each year.

(e)(1) Whenever legislation containing a mandated health insurance benefit or provider is proposed, the standing committee of the General Assembly having jurisdiction over the proposal shall request that the advisory commission prepare and forward to the Governor and the General Assembly a study that assesses the social and financial impact and the medical efficacy of the proposed mandate. The advisory commission shall be given a period of six months, or until commencement of the next General Assembly, whichever is longer, to complete and submit its assessment.

(2) The advisory commission shall assess the social and financial impact and the medical efficacy of existing mandated benefits and providers in effect as of January 1, 2012. The advisory commission shall submit a schedule of evaluations to the standing committees of the General Assembly having jurisdiction over health insurance matters by May 1, 2012, setting forth the dates by which particular mandates shall be evaluated by the advisory commission. The evaluations shall be completed and submitted to such standing committees no later than December 31, 2012.

(f) The Insurance Department, the Department of Labor, the Department of Community Health, and such other state agencies as may be considered appropriate by the advisory commission shall provide staff assistance to the advisory commission. (Code 1981, § 33-1-19, enacted by Ga. L. 2011, p. 329, § 1/SB 17; Ga. L. 2012, p. 775, § 33/HB 942.)

Effective date. — This Code section became effective July 1, 2011.

The 2012 amendment, effective May 1, 2012, part of an Act to revise, modernize, and correct the Code, substituted "Insurance Department" for "Department of Insurance" in paragraphs (d)(1) and (d)(2) and in subsection (f).

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2011, Code Section 33-1-19, as enacted by Ga. L. 2011, p. 350, § 1, was redesignated as Code Section 33-1-20.

33-1-20. Health care sharing ministry defined; health care sharing ministry entering into health care cost sharing arrangements with participants not considered insurance company, health maintenance organization, or health benefit plan.

(a) As used in this Code section, the term "health care sharing ministry" means a faith-based, nonprofit organization that is tax exempt under the Internal Revenue Code which:

(1) Limits its participants to those who are of a similar faith;

(2) Acts as a facilitator among participants who have financial or medical needs and matches those participants with other participants with the present ability to assist those with financial or medical needs in accordance with criteria established by the health care sharing ministry;

(3) Provides for the financial or medical needs of a participant through contributions from one participant to another;

(4) Provides amounts that participants may contribute with no assumption of risk or promise to pay among the participants and no assumption of risk or promise to pay by the health care sharing ministry to the participants;

(5) Provides a written monthly statement to all participants that lists the total dollar amount of qualified needs submitted to the health care sharing ministry, as well as the amount actually published or assigned to participants for their contribution; and

(6) Provides a written disclaimer on or accompanying all applications and guideline materials distributed by or on behalf of the organization that reads, in substance: "Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payment for medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills."

(b) A health care sharing ministry which has entered into a health care cost sharing arrangement with its participants shall not be considered an insurance company, health maintenance organization, or health benefit plan of any class, kind, or character and shall not be subject to any laws respecting insurance companies, health maintenance organizations, or health benefit plans of any class, kind, or character in this state or subject to regulation under such laws, including, but not limited to, the provisions of this title, and shall not be subject to the jurisdiction of the Commissioner of Insurance. (Code 1981, § 33-1-20, enacted by Ga. L. 2011, p. 350, § 1/HB 248.)

Effective date. — This Code section became effective July 1, 2011.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2011, Code Section 33-1-19, as enacted by Ga. L. 2011, p. 350, § 1, was redesignated as Code Section 33-1-20 and Code Section 33-1-20, as enacted by Ga. L. 2011, p. 350, § 1, was redesignated as Code Section 33-1-21.

33-1-21. Certain subscription agreements for prepaid air ambulance service not contract of insurance; definitions.

(a) As used in this Code section, the term:

(1) "Air ambulance" means any rotary-wing aircraft used or intended to be used for hire for transportation of sick or injured persons who may need medical attention during transport.

(2) "Air ambulance service" means the for-hire providing of emergency care and transportation by means of an air ambulance for an injured or sick person to or from a place where medical or hospital care is furnished.

(3) "Membership fees" means amounts collected by a membership provider as consideration for a membership subscription.

(4) "Membership provider" means an entity that is licensed to provide air ambulance services pursuant to Chapter 11 of Title 31.

(5) "Membership subscription" means an agreement where a membership provider's charges to a subscription member for air ambulance services are discounted or are prepaid, but only for charges that are not otherwise covered by a third party.

(6) "Subscription member" means an individual who is the beneficiary of a membership subscription.

(b)(1) The solicitation of membership subscriptions, the acceptance of applications for membership subscriptions, the charging of membership fees, and the furnishing of prepaid or discounted air ambulance service to subscription members by a membership provider shall not constitute the writing of insurance.

(2) A membership subscription shall not constitute a contract of insurance. (Code 1981, § 33-1-21, enacted by Ga. L. 2011, p. 350, § 1/HB 248.)

Effective date. — This Code section became effective July 1, 2011.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2011, Code Section 33-1-20, as enacted by Ga. L. 2011, p. 350, § 1, was redesignated as Code Section 33-1-21.

33-1-22. English language version of policy controls.

In the event of a dispute or complaint wherein an insurer provided any material in a language other than English, the English language version of the policy, as that term is defined in Code Section 33-24-1, shall control the resolution of such dispute or complaint; provided, however, that nothing contained in this Code section shall abrogate or supersede the provisions set forth in Chapter 6 of this title, relating to unfair trade practices. (Code 1981, § 33-1-22, enacted by Ga. L. 2012, p. 1350, § 8A/HB 1067.)

Effective date. — This Code section became effective July 1, 2012.

Cross references. — English designated as official language, § 50-3-100.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2012, Code Section 33-1-22, as enacted by Ga. L. 2012, p. 348, § 1/HB 785, was redesignated as Code Section 43-1-32.

CHAPTER 2

DEPARTMENT AND COMMISSIONER OF INSURANCE

JUDICIAL DECISIONS

Action involving insurance violations. — A consumer class action complaint asserting various claims against an insurance company, including claims for fraud, Georgia RICO, and breach of contract was erroneously dismissed on the basis that the Insurance Commissioner had exclusive jurisdiction and that plaintiffs were required to exhaust their administrative remedies before the Insurance Commissioner before filing an action in court. Griffeth v. Principal Mut. Ins. Co., 243 Ga. App. 618, 533 S.E.2d 126 (2000).

33-2-2. (Effective January 1, 2013. See note.) Seal of Commissioner.

The Commissioner shall have an official seal of such design as he or she shall select with the approval of the Governor. (Code 1933, § 56-202, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2011, p. 99, § 45/HB 24.)

Delayed effective date. — This Code section, as set forth above, is effective on January 1, 2013. For the version of this Code section effective until that date, see the bound volume.

The 2011 amendment, effective January 1, 2013, inserted "or she" in the middle of the first sentence and deleted the former second sentence, which read: "Every certificate and other document or paper executed by the Commissioner in the pursuance of any authority conferred upon him by law and sealed with the seal of his office and all copies or photographic copies of papers certified by him and authenticated by said seal shall in all cases be evidence "in equal and like manner" as the original thereof and shall in all cases be primary evidence of the contents of the original and shall be admissible in any court in this state." See editor's note for applicability.

Editor's notes. — Ga. L. 2011, p. 99, § 101, not codified by the General Assembly, provides that the amendment to this Code section by that Act shall apply to any motion made or hearing or trial commenced on or after January 1, 2013.

Law reviews. — For article, "Evidence," see 27 Ga. St. U. L. Rev. 1 (2011). For article on the 2011 amendment of this Code section, see 28 Ga. St. U. L. Rev. 1 (2011).

33-2-6. Delegated authority.

JUDICIAL DECISIONS

Cited in Blue Cross & Blue Shield of Ga., Inc. v. Deal, 244 Ga. App. 700, 536 S.E.2d 590 (2000).

33-2-8.1. Purpose of Code section; preparation by Commissioner of supplemental report on property and casualty insurance; contents of report; request for information.

(a) The General Assembly and the public have been confronted with a need for relevant and verifiable information on the property and casualty insurance industry. The purpose of this Code section is to provide the General Assembly and the public with accessible information on the property and casualty insurance industry, on the solvency of such insurers, on market availability and profitability, and on troubled liability insurance lines.

(b) On July 1 of each year, the Commissioner, as a supplemental report to the annual report provided in Code Section 33-2-8, shall compile a report containing the information specified in this Code section. The Commissioner shall not be required to distribute copies of the supplemental report to the members of the General Assembly but shall notify the members of the availability of the supplemental report in the manner which he or she deems to be most effective and efficient.

(c) The Commissioner shall investigate every licensed property and casualty insurer that is designated by the National Association of Insurance Commissioners as needing immediate or targeted regulatory attention and shall include in his report the number of such insurers which his investigation confirms are in need of immediate or targeted regulatory attention and the names of such insurers which are in formal rehabilitation, liquidation, or conservatorship. The Commissioner shall obtain from the National Association of Insurance Commissioners the necessary information to implement this subsection and, notwithstanding the provisions of Article 4 of Chapter 18 of Title 50, shall withhold from public inspection any such information received from the National Association of Insurance Commissioners under an expectation of confidentiality.

(d) The Commissioner shall include in his report an evaluation of the insurance coverages considered by him to be unavailable or unaffordable with regard to the following lines, classes, and subclasses of insurance:

(1) Owners, landlords, and tenants;

(2) Manufacturers and contractors;

(3) Products and completed operations;

(4) Governmental subdivisions;

(5) Public schools;

(6) Day-care centers;

(7) Liquor retailers;

(8) Recreational;

(9) Professional liability;

(10) Medical malpractice;

(11) Commercial and private passenger automobile and all other general liability; and

(12) Workers' compensation.

(e) In considering insurance coverages that are unavailable or unaffordable the Commissioner shall include, if practicable, in his report, for a five-year period on either a prospective or retrospective basis, on a state basis, and on an aggregate country-wide basis, the following information for each licensed property and casualty insurer and each residual market mechanism:

(1) The number of policies written as of December 31 of each year;

(2) The number of policies canceled or nonrenewed and whether the policies were canceled by the insurer or the insured;

(3) Major trends in policy forms;

(4) Limits and deductibles offered;

(5) Trends in increases or decreases in premiums; and

(6) Earned premiums, total limits incurred losses, loss ratios, and the number of incurred claims for policies written and premiums written.

(f) The Commissioner shall include in his report consumer information on market assistance programs and joint underwriting associations. The Commissioner shall also include in his report a summary of actions taken by the department on personal lines property and

casualty insurance rate filings that result in the filing of lower rates by insurance companies and estimates of the amount of money saved by consumers as a result of such actions.

(g) The Commissioner shall have the authority to require property and casualty insurers to submit any information necessary to enable him to compile the supplemental report required by this Code section. (Code 1981, § 33-2-8.1, enacted by Ga. L. 1989, p. 885, § 1; Ga. L. 1990, p. 8, § 33; Ga. L. 1990, p. 1496, § 1; Ga. L. 2005, p. 1036, § 25/SB 49; Ga. L. 2012, p. 218, § 8/HB 397.)

The 2005 amendment, effective July 1, 2005, in subsection (b), in the first sentence, substituted "On" for "By July 1, 1990, and on", deleted "thereafter" following "of each year", and deleted "and shall distribute such supplemental report to each member of the General Assembly" at the end; and added the second sentence.

The 2012 amendment, effective April 17, 2012, substituted "Article 4 of Chapter 18 of Title 50" for "Code Section 50-18-70" in the last sentence of subsection (c).

33-2-10. Issuance and service of orders and notices.

(a) Orders and notices of the Commissioner shall be effective only when they are in writing and signed by him or by his authority.

(b) Every such order shall state its effective date and shall state concisely:

(1) Its intent or purpose;

(2) The grounds on which it is based; and

(3) The provisions of this title pursuant to which action is taken or proposed to be taken; but failure to designate any provision shall not deprive the Commissioner of the right to rely thereon.

(c) An order or notice may be served by delivery to the person to be ordered or notified or by mailing it, postage prepaid, addressed to him at his principal place of business or last address of record in the Commissioner's office.

(d) In addition to the service provisions set forth in subsection (c) of this Code section, any order of the Commissioner issued to multiple recipients in the form of a general directive, data call, or bulletin may be served by sending it by electronic mail, so that receipt is acknowledged by the recipient, to the electronic mail address on record in the Commissioner's office. The Commissioner shall also post such general directive, data call, or bulletin contemporaneously on the department's website. (Code 1933, § 56-217, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2004, p. 754, § 1.)

The 2004 amendment, effective May 13, 2004, added subsection (d).

33-2-11. Examination of insurers and organizations; effect of insurer's change of domicile from Georgia.

(a) Whenever the Commissioner shall deem it expedient, the Commissioner shall examine, either in person or by some examiner duly authorized by the Commissioner, the affairs, transactions, accounts, records, documents, and assets of each insurer authorized to do business in this state and any other facts relative to its business methods, management, and dealings with policyholders. At least once every five years, the Commissioner shall so examine each domestic insurer. Examination of an alien insurer shall be limited to its insurance transactions in the United States.

(b) Whenever he shall deem it necessary at least once in five years, the Commissioner shall fully examine each rating organization which is licensed in this state. As often as he shall deem it necessary, he may examine each advisory organization and each joint underwriting or joint reinsurance group, association, or organization.

(c) The Commissioner shall in like manner examine each insurer or rating organization applying for authority to do business in this state.

(d) In lieu of an examination under this Code section of any foreign or alien insurer licensed in this state, the Commissioner may accept an examination report on such insurer as prepared by the insurance department of such insurer's state of domicile or port-of-entry state until January 1, 1994. On and after January 1, 1994, such reports may be accepted only if:

(1) The insurance department was, at the time the examination was conducted, accredited under the National Association of Insurance Commissioners' financial regulation standards and accreditation program; or

(2) The examination was performed under the supervision of an accredited insurance department or with the participation of one or more examiners who are employed by an accredited state insurance department and who, after a review of the examination work papers and report, state under oath that the examination was performed in a manner consistent with the standards and procedures required by their insurance department.

(e) Any insurer authorized to transact insurance in this state which changes its domicile from Georgia to another state on or after April 1, 1988, may be examined by the Commissioner once a year for five years, beginning on or after the occurrence of the change in domicile; provided, however, this subsection shall not apply to an insurer which changes its domicile from Georgia to another state as long as it retains in this state its principal place of business and the complete records of its assets,

transactions, and affairs. (Code 1933, § 56-208, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1988, p. 692, § 1; Ga. L. 1989, p. 562, § 1; Ga. L. 1990, p. 8, § 33; Ga. L. 1992, p. 2877, § 1; Ga. L. 2000, p. 1246, § 1; Ga. L. 2008, p. 1090, § 1/SB 471.)

The 2008 amendment, effective July 1, 2008, in subsection (a), in the first sentence, substituted "the Commissioner shall" for "he shall" near the beginning and substituted "the Commissioner" for "him" near the middle; and, in the second sentence, substituted "five years, the Commissioner" for "three years, he".

33-2-14. Preparation of written reports of examinations generally; certification of reports; admissibility in evidence; notice and hearing on reports; use of examination documents.

(a) The Commissioner may make a full written report of each examination made by him containing only facts ascertained from the accounts, records, and documents examined and from the sworn testimony of witnesses.

(b) The report shall be certified by the Commissioner or by the examiner in charge of the examination and when so certified, after filing as provided in subsection (c) of this Code section, shall be admissible in evidence in any proceeding brought by the Commissioner against the person examined or any officer or agent of such person and shall be prima-facie evidence of the facts stated therein.

(c) The Commissioner shall furnish a copy of the proposed report to the person examined not less than 20 days prior to filing the report. If such person so requests in writing within such 20 day period or such longer period as the Commissioner may grant, the Commissioner shall grant a hearing with respect to the report and shall not so file the report until after the hearing and such modifications have been made therein as the Commissioner may deem proper.

(d) The Commissioner may withhold from public inspection the report of any examination or investigation for so long as he deems it to be in the public interest or necessary to protect the person examined from unwarranted injury.

(e) Nothing contained in this Code section shall be construed to limit the Commissioner's authority to terminate or suspend any examination in order to pursue other legal or regulatory action pursuant to the insurance laws of this state. In such event, the findings of fact and conclusions made pursuant to said examination and prior to any hearing as set forth in subsection (c) of this Code section shall be prima-facie evidence in any legal or regulatory action.

(f) In the event the Commissioner determines that regulatory action is appropriate as a result of any examination, he or she may initiate any proceeding or actions as provided by law.

(g) Notwithstanding the provisions of Article 4 of Chapter 18 of Title 50, relating to the inspection of public records, all work papers, analysis, information, documents, information received from another state, and any other materials created, produced, or obtained by or disclosed to the Commissioner or any other person in the course of an examination made under this chapter or in the course of analysis by the Commissioner of the financial condition or market conduct of a company must be given confidential treatment and are not subject to subpoena and may not be made public by the Commissioner or any other person. Access may be granted to authorized representatives of the National Association of Insurance Commissioners. Such representatives must agree in writing prior to receiving the information to treat such information confidentially as required by this Code section, unless the prior written consent of the company to which it pertains has been obtained.

(h) Nothing contained in this Code section shall be construed to limit the Commissioner's authority to use any preliminary or final examination or company work papers or other documents, or any other information discovered or developed during the course of any examination in the furtherance of any legal or regulatory action which the Commissioner may, in his or her sole discretion, deem appropriate.

(i) Nothing contained in this Code section shall prevent or be construed as prohibiting the Commissioner from disclosing the work papers, analysis, information, or a document described in subsection (g) of this Code section to state, federal, or international regulatory agencies or state, federal, or international law enforcement authorities so long as such recipient agrees in writing to treat such report confidentially and in a manner consistent with this title. (Code 1933, § 56-211, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1992, p. 2877, § 3; Ga. L. 2008, p. 1090, § 2/SB 471; Ga. L. 2012, p. 1117, § 1/SB 385.)

The 2008 amendment, effective July 1, 2008, substituted "documents, copies received from another state, and any other materials created, produced, or obtained by or" for "and documents and copies received from another state and" in the first sentence of subsection (g).

The 2012 amendment, effective July 1, 2012, in the first sentence of subsection (g), substituted "analysis, information, documents, information" for "recorded information, documents, copies" near the beginning, and inserted "or in the course of analysis by the Commissioner of the financial condition or market conduct of a company" near the middle; and substituted "work papers, analysis, information, or a document described in subsection (g) of this Code section to state, federal, or international regulatory agencies or state, federal, or international law enforcement authorities so long as such recipient" for "contents of an examination report, preliminary examination report, or results or any matter relating thereto to the insurance department of this or any other state or country or to law enforcement officials of this or any other state or agency of the federal government at any time so long as such agency or office receiving the report or matter relating thereto" in subsection (i).

33-2-15. Payment of expenses of examinations; immunity of examiners.

(a) At the direction of the Commissioner, the insurer or other person so examined shall pay all the actual travel and living expenses of the examination. When the examination is made by an examiner who is not a regular employee of the department, the person examined shall pay the proper charges for the services of the examiner and his or her assistants and the actual travel and living expenses incurred by such examiners and assistants in an amount approved by the Commissioner. A consolidated account for the examination shall be filed by the examiner with the Commissioner. No person shall pay and no examiner shall accept any additional emolument on account of any examination. When the examination is conducted in whole or in part by regular salaried employees of the department, payment for such services and proper expenses shall be made by the person examined to the Commissioner, and such payment shall be deposited in the state treasury; provided, however, that, when an agent, broker, solicitor, counselor, or adjuster is examined because of a complaint filed against such agent, broker, solicitor, counselor, or adjuster and when the Commissioner finds that the complaint was not justified, the expenses of the examination shall not be assessed against the agent, broker, solicitor, counselor, or adjuster but shall be borne by the department.

(b) An examiner or other person appointed or authorized by the Commissioner, while participating in an examination conducted under this chapter, shall enjoy the same immunities as those of a regular employee of the department under similar circumstances. (Code 1933, § 56-212, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 1985, p. 1087, § 1; Ga. L. 2008, p. 1090, § 3/SB 471.)

The 2008 amendment, effective July 1, 2008, designated the existing provisions as subsection (a); in subsection (a), inserted "or her" near the middle of the second sentence; and added subsection (b).

33-2-17. Conduct of hearings by Commissioner generally; demands for hearings.

JUDICIAL DECISIONS

Cited in Darden v. Ford Consumer Fin. Co., 200 F.3d 753 (11th Cir. 2000); Blue Cross & Blue Shield of Ga., Inc. v. Deal, 244 Ga. App. 700, 536 S.E.2d 590 (2000).

33-2-24. Enforcement of title and rules, regulations, and orders; issuance of orders without hearings; civil actions; criminal violations; penalties.

(a) Whenever it may appear to the Commissioner, either upon investigation or otherwise, that any person has engaged in, is engaging in, or is about to engage in any act, practice, or transaction which is prohibited by this title or by any rule, regulation, or order of the Commissioner promulgated or issued pursuant to this title or which is declared to be unlawful under this title, the Commissioner may at his discretion issue an order, if he deems it to be appropriate in the public interest or for the protection of policyholders or the citizens of this state, prohibiting such person from continuing such act, practice, or transaction.

(b) Notwithstanding any other provision of this title, in situations where persons otherwise would be entitled to a hearing prior to an order, the Commissioner may issue a proposed order to be effective upon a later date without hearing, unless persons subject to the order request a hearing within ten days after receipt of the order. Failure to make the request shall constitute a waiver of any provision of law for the hearing. The order shall contain or shall be accompanied by a notice of opportunity for hearing which clearly explains that the opportunity must be requested within ten days of receipt of the order and notice. The order and notice shall be served in person by the Commissioner or his agent or by registered or certified mail or statutory overnight delivery, return receipt requested.

(c) Notwithstanding any other provision of this title, in situations where persons otherwise would be entitled to a hearing prior to an order, the Commissioner may issue an order to be effective immediately, if the Commissioner has reasonable cause to believe: that an act, practice, or transaction is occurring or is about to occur; that the situation constitutes a situation of imminent peril to the public health, safety, or welfare; and that the situation therefore imperatively requires emergency action. The emergency order shall contain findings to this effect and reasons for the determination. The order shall contain or be accompanied by a notice of opportunity for hearing which may provide that a hearing will be held if and only if a person subject to the order requests a hearing within ten days of receipt of the order and notice. The order and notice shall be served by delivery by the Commissioner or his agent or by registered or certified mail or statutory overnight delivery, return receipt requested.

(d) The Commissioner may institute actions or other legal proceedings as may be required for the enforcement of any provisions of this title. If the Commissioner has reason to believe that any person has

violated any provision of this title for which criminal prosecution is provided, he shall so inform the prosecuting attorney in whose circuit or jurisdiction such violation may have occurred.

(e) The Commissioner may prosecute an action in any superior court of proper venue to enforce any order made by him pursuant to this title.

(f) In cases in which the Commissioner institutes an action or other legal proceeding in a superior court of this state or prosecutes an action in a superior court to enforce his order, the superior court may among other appropriate relief issue an injunction restraining persons and those in active concert with them, including agents, employees, partners, officers, and directors, from engaging in acts prohibited by orders of the Commissioner or his rules or regulations or made unlawful or prohibited by this title.

(g) In addition to all other penalties provided for under this title, the Commissioner shall have the authority to place any insurer, agent, broker, counselor, solicitor, administrator, or adjuster on probation for a period of time not to exceed one year for each and every act in violation of this title or of the rules and regulations or orders of the Commissioner and may subject such insurer, agent, broker, counselor, solicitor, administrator, or adjuster to a monetary penalty of up to $2,000.00 for each and every act in violation of this title or of the rules, regulations, or orders of the Commissioner, unless the insurer, agent, broker, counselor, solicitor, administrator, or adjuster knew or reasonably should have known he or she was in violation of this title or of the rules and regulations or orders of the Commissioner, in which case the monetary penalty provided for in this subsection may be increased to an amount up to $5,000.00 for each and every act in violation. (Code 1933, § 56-214, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1975, p. 1245, § 1; Ga. L. 1976, p. 411, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 2000, p. 136, § 33; Ga. L. 2000, p. 1589, § 3; Ga. L. 2005, p. 563, § 1/HB 407; Ga. L. 2010, p. 9, § 1-63/HB 1055.)

The 2005 amendment, effective July 1, 2005, inserted "administrator," in three places in subsection (g).

The 2010 amendment, effective May 12, 2010, in subsection (g), substituted "$2,000.00" for "$1,000.00" near the middle and inserted "or she" near the end.

JUDICIAL DECISIONS

Cited in Am. Ass'n of Cab Cos. v. Parham, 291 Ga. App. 33, 661 S.E.2d 161 (2008); State Farm Mut. Auto. Ins. Co. v. Hernandez Auto Painting & Body Works, 312 Ga. App. 756, 719 S.E.2d 597 (2011).

33-2-26. Judicial review of actions of Commissioner — Persons entitled to appeal; procedure generally.

JUDICIAL DECISIONS

Review of order on plan of conversion. — The orders encompassed by this section include hearings to determine the propriety of plans of conversion set forth in § 33-20-34. Blue Cross & Blue Shield of Ga., Inc. v. Deal, 244 Ga. App. 700, 536 S.E.2d 590 (2000).

33-2-27. Judicial review of actions of Commissioner — Pleading and procedure; powers of reviewing court generally.

Law reviews. — For article, "Administrative Law," see 53 Mercer L. Rev. 81 (2001).

JUDICIAL DECISIONS

Review of order on plan of conversion. — The orders encompassed by § 33-2-26 on appeals from actions of the Commissioner include hearings to determine the propriety of plans of conversion set forth in § 33-20-34. Blue Cross & Blue Shield of Ga., Inc. v. Deal, 244 Ga. App. 700, 536 S.E.2d 590 (2000).

33-2-29. Disposition of amounts collected under title generally; allowance of refunds and credits.

The Commissioner shall promptly pay all taxes, fees, dues, charges, and penalties and interest which he is authorized to collect under this title to the Office of the State Treasurer to the credit of the general fund. The Commissioner, however, is authorized to make refunds of or to allow credits for any amounts which have been illegally or erroneously paid or collected pursuant to any provision of this title; and such payments to the Office of the State Treasurer shall be less the amount of any such refunds or credits, provided that no refunds or credits shall be allowed under this Code section unless a written request for such refund or credit is filed with the Commissioner within seven years from the date of payment or collection of the amount for which a refund or credit is claimed. (Code 1933, § 56-228, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1976, p. 1080, § 1; Ga. L. 1993, p. 1402, § 18; Ga. L. 2010, p. 863, § 2/SB 296.)

The 2010 amendment, effective July 1, 2010, substituted "Office of the State Treasurer" for "Office of Treasury and Fiscal Services" in two places in this Code section.

33-2-33. (For effective date, see note) List of written requests for assistance by citizens against insurers.

Delayed effective date. — Section 2 of Ga. L. 1989, p. 633, not codified by the General Assembly, provides: "This Act shall become effective only when the funds necessary to carry out its purposes are appropriated by the General Assembly." Such funds were not appropriated during the 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, or 2012 sessions of the General Assembly.

CHAPTER 3

AUTHORIZATION AND GENERAL REQUIREMENTS FOR TRANSACTION OF INSURANCE

33-3-2. Certificate of authority required for transaction of insurance within state; exceptions.

JUDICIAL DECISIONS

Preservation of right to raise untimely notice objection. — Surplus insurers were authorized to file a declaratory judgment action to preserve their right to raise untimely notice of an occurrence as a defense to coverage even without a certificate of authority to conduct business in the state of Georgia. Kay-Lex Co. v. Essex Ins. Co., 286 Ga. App. 484, 649 S.E.2d 602 (2007).

33-3-4. Kinds of insurance in which insurers may transact.

An insurer which otherwise qualifies to transact insurance in Georgia may be authorized to transact any one kind or combination of kinds of insurance as defined in Chapter 7 of this title except:

(1) A reciprocal insurer shall not transact life insurance;

(2) A Lloyd's insurer shall not transact life insurance; and

(3) A title insurer shall be a stock insurer and shall be authorized to transact only title insurance and closing protection letters, pursuant to Code Section 33-7-8.1, except that, if immediately prior to January 1, 1961, any title insurer lawfully held a subsisting certifi-

cate of authority granting it the right to transact in Georgia additional classes of insurance other than title insurance, so long as the insurer is otherwise in compliance with this title, the Commissioner shall continue to authorize such insurer to transact the same classes of insurance as those specified in such prior certificate of authority. (Code 1933, § 56-304, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 2012, p. 1077, § 1/SB 331.)

The 2012 amendment, effective May 2, 2012, substituted "be authorized to transact only title insurance and closing protection letters, pursuant to Code Section 33-7-8.1" for "not to be authorized to transact any other class of insurance" in paragraph (3).

33-3-15. Issuance or refusal of certificate of authority generally; determining whether insurer meets definition of reinsurer; designation on certificate.

(a) Upon filing of an application for an original certificate of authority, the Commissioner shall have 90 days in which to approve the application by issuing an appropriate certificate of authority or disapprove the application by issuing an order setting forth the grounds for such disapproval. The Commissioner may extend such 90 day period for an additional 90 days by notifying the applicant in writing of such extension. If the application is not approved or disapproved within such time period or periods, the application shall be deemed approved and the Commissioner shall thereupon issue the appropriate certificate of authority.

(b) The certificate, if issued, shall specify the kind or kinds of insurance the insurer is authorized to transact in Georgia. At the insurer's request, the Commissioner may issue a certificate of authority limited to particular types of insurance included within a kind of insurance as defined in this title.

(c) The Commissioner shall determine if the insurer is a reinsurer and shall so designate on the certificate. As used in this subsection, the term "reinsurer" means an insurer that is principally engaged in the business of reinsurance, does not conduct significant amounts of direct insurance as a percentage of its net premiums, and is not engaged in an ongoing basis in the business of soliciting direct insurance. (Code 1933, § 56-314, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2011, p. 622, § 1/SB 252.)

The 2011 amendment, effective July 1, 2011, substituted "such time period or periods," for "the time period as above set forth" in the last sentence of subsection (a); and added subsection (c).

33-3-21.3. Annual filings with National Association of Insurance Commissioners; agents of Commissioner not subject to civil liability; confidentiality of information.

Editor's notes. — Section 9 of SB 347 (Ga. L. 1991, p. 1424), not codified by the General Assembly, contained inconsistencies in references to the sections of the bill due to differences in the section numbers contained in the Senate version of the bill and the final version of the bill. Subsection (b) of Section 9 refers to Code Section 33-7-14 in the Senate version of SB 347.

33-3-23. Restrictions as to transaction of insurance by certain organizations — Lending institutions and bank holding companies.

OPINIONS OF THE ATTORNEY GENERAL

Preemption by federal law. — The Gramm-Leach-Bliley Act (Pub. L. No. 106-102, 113 Stat. 1338 (1999)) preempts the provisions of this section restricting lending institutions, bank holding companies, and their subsidiaries and affiliates from selling insurance in municipalities with populations exceeding 5,000. 2000 Op. Att'y Gen. No. 2000-4.

33-3-26. Retaliation.

(a) When by or pursuant to the laws of any other state or foreign country any taxes, licenses, and other fees in the aggregate and any fines, penalties, deposit requirements, or other material obligations, prohibitions, or restrictions are or would be imposed upon Georgia insurers or upon the agents or representatives of such insurers which are in excess of such taxes, licenses, and other fees in the aggregate or which are in excess of the fines, penalties, deposit requirements, or other obligations, prohibitions, or restrictions directly imposed upon similar insurers or upon the agents or representatives of such insurers of such other state or country under the statutes of this state, so long as such laws of such other state or country continue in force or are so applied, the same taxes, licenses, and other fees in the aggregate or fines, penalties, deposit requirements, or other material obligations, prohibitions, or restrictions of whatever kind shall be imposed by the Commissioner upon the insurers or upon the agents or representatives of such insurers of such other state or country doing business or seeking to do business in Georgia. Any tax, license, or other fee or other obligation imposed by any city, county, or other political subdivision or agency of such other state or country on Georgia insurers or their agents or representatives shall be deemed to be imposed by such state or country within the meaning of this Code section.

(b) The Commissioner may waive any retaliatory obligations, prohibitions, or restrictions that would prohibit entry into this state of any insurer domiciled in another state and that would otherwise be imposed

by subsection (a) of this Code section if, in his or her discretion, the entry of such insurer would be expected to enhance competition in this state and would be in the best interests of the citizens of this state. The discretion provided by this subsection shall not extend to any retaliatory taxes, fees, fines, penalties, or deposit requirements.

(c) This Code section shall not apply as to personal income taxes, as to ad valorem taxes on real or personal property, or as to special purpose obligations or assessments imposed by another state in connection with particular kinds of insurance other than property insurance, except that deductions from premium taxes or other taxes otherwise payable allowed on account of real estate or personal property taxes paid shall be taken into consideration by the Commissioner in determining the propriety and extent of retaliatory action under this Code section.

(d) For the purposes of this Code section, the domicile of an alien insurer other than insurers formed under the laws of Canada shall be that state designated by the insurer in writing filed with the Commissioner at the time of admission to this state and may be any one of the following states:

(1) This state if the insurer is entering through this state to transact insurance in the United States through a United States branch;

(2) That in which the insurer was first authorized to transact insurance;

(3) That in which is located the insurer's principal place of business in the United States; or

(4) That in which is held the larger deposit of trusteed assets of the insurer for the protection of its policyholders and creditors in the United States.

(e) If the insurer makes no such designation, its domicile shall be deemed to be that state in which is located its principal place of business in the United States.

(f) In the case of an insurer formed under the laws of Canada or a province thereof, its domicile shall be deemed to be that province in which its head office is situated. (Ga. L. 1869, p. 127, § 5; Code 1873, § 2848; Code 1882, § 2848; Ga. L. 1887, p. 124, § 12; Civil Code 1895, § 2060; Civil Code 1910, § 2449; Code 1933, § 56-315; Code 1933, § 56-321, enacted by Ga. L. 1960, p. 289, § 1; Code 1981, § 33-3-25; Ga. L. 1982, p. 3, § 33; Code 1981, § 33-3-26, as redesignated by Ga. L. 1982, p. 1244, § 1; Ga. L. 1999, p. 584, § 3; Ga. L. 2008, p. 482, § 1/SB 213.)

The 2008 amendment, effective July 1, 2008, redesignated former subsections (b) through (e) as present subsections (c) through (f), respectively; added present subsection (b); and inserted a comma following "designation" in subsection (e).

33-3-27. Reports of awards under medical malpractice insurance policies.

(a) For the purposes of this Code section, the term "medical malpractice claim" means any claim for damages resulting from the death of or injury to any person arising out of health, medical, or surgical service, diagnosis, prescription, treatment, or care rendered by a person authorized by law to practice medicine in this state or by any person acting under such person's supervision and control.

(b) Every insurer providing medical malpractice insurance coverage in this state shall notify in writing the Georgia Composite Medical Board when it pays a judgment or enters into an agreement to pay an amount to settle a medical malpractice claim against a person authorized by law to practice medicine in this state. Such judgments or agreements shall be reported to the board regardless of the dollar amount. Such notice shall be sent within 30 days after the judgment has been paid or the agreement has been entered into by the parties involved in the claim. (Code 1981, § 33-3-27, enacted by Ga. L. 1983, p. 882, § 2; Ga. L. 1992, p. 6, § 33; Ga. L. 2005, p. 1, § 8/SB 3; Ga. L. 2009, p. 859, § 2/HB 509.)

The 2005 amendment, effective February 16, 2005, in subsection (b), deleted "in excess of $10,000.00" following "when it pays a judgment" and following "an agreement to pay an amount" in the first sentence, substituted ". Such" for "; such" at the end of the first sentence, and deleted "if the records of the insurer establish that there have been two or more previous judgments against or settlements with a licensed physician which relate to the practice of medicine" following "dollar amount" at the end of the second sentence.

The 2009 amendment, effective July 1, 2009, substituted "Georgia Composite Medical Board" for "Composite State Board of Medical Examiners" near the middle of the first sentence of subsection (b).

Editor's notes. — Ga. L. 2005, p. 1, § 1, not codified by the General Assembly, provides that: "The General Assembly finds that there presently exists a crisis affecting the provision and quality of health care services in this state. Hospitals and other health care providers in this state are having increasing difficulty in locating liability insurance and, when such hospitals and providers are able to locate such insurance, the insurance is extremely costly. The result of this crisis is the potential for a diminution of the availability of access to health care services and a resulting adverse impact on the health and well-being of the citizens of this state. The General Assembly further finds that certain civil justice and health care regulatory reforms as provided in this Act will promote predictability and improvement in the provision of quality health care services and the resolution of health care liability claims and will thereby assist in promoting the provision of health care liability insurance by insurance providers. The General Assembly further finds that certain needed reforms affect not only health care liability claims but also other civil actions and accordingly provides such general reforms in this Act."

Law reviews. — For article on 2005

amendment of this section, see 22 Ga. St. U. L. Rev. 221 (2005).

33-3-28. Request by claimant for information as to name of insurer, name of each insured, and limits of coverage.

JUDICIAL DECISIONS

Improper insurance reporting may result in liability. — Since defendant insurance company failed to disclose the existence of an umbrella policy until after the claimant had settled for what she thought were the policy limits, the trial court erred in granting summary judgment to the company on the claimant's allegations of fraud, misrepresentation and false swearing, based on its conclusion that the parties had no contract because the parties' settlement agreement was contingent on the company having disclosed all applicable policies. Merritt v. State Farm Mut. Auto. Ins. Co., 247 Ga. App. 442, 544 S.E.2d 180 (2000).

Failing to disclose existence of insurance was willful and malicious act. — Debtor performed a willful and malicious act, 11 U.S.C. § 523(a)(6), by failing to disclose the existence of insurance. Contrary to the mandate of O.C.G.A. § 33-3-28(a)(2), the debtor did not comply with the creditor's personal injury attorney's request for insurance information and instead gave the creditor false and misleading information; the debtor's concealment of insurance information caused harm to the creditor that was both willful and malicious. Blair v. Boughter (In re Boughter), 463 Bankr. 908 (Bankr. S.D. Ga. 2003).

Cited in State Farm Mut. Auto. Ins. Co. v. Hernandez Auto Painting & Body Works, 312 Ga. App. 756, 719 S.E.2d 597 (2011).

CHAPTER 4

ACTIONS AGAINST INSURANCE COMPANIES

Sec.

33-4-1. Venue of actions.

Law reviews. — For survey article on real property law for the period from June 1, 2002 to May 31, 2003, see 55 Mercer L. Rev. 397 (2003).

JUDICIAL DECISIONS

Analysis

General Consideration

Application

General Consideration

Construction of paragraph (2).

Paragraph (2) can be used to fix venue for a tort action in any county where a defendant insurance company has an agent, as long as the action involves the defendant's insurance business. Travelers, Inc. v. Patterman, 272 Ga. 251, 527 S.E.2d 187 (2000).

Cited in Jackson v. Sluder, 256 Ga. App. 812, 569 S.E.2d 893 (2002).

Application

Section applies to action involving unknown uninsured motorist.

Insureds were authorized to bring their action against their insurer, seeking uninsured motorist coverage, in the county of their residence pursuant to O.C.G.A. § 33-4-1(4) and, accordingly, the trial court erred in transferring their case to another county pursuant to the insurer's motion alleging improper venue; the matter of whether venue was proper was reviewable by the appellate court pursuant to O.C.G.A. § 5-6-34(d) where the insureds' matter had been dismissed by the trial court and they sought review thereof. Morton v. Fuller, 264 Ga. App. 799, 592 S.E.2d 460 (2003).

Pleading seeking equitable relief.

Columbia County Superior Court did not have personal jurisdiction over an insurance policy beneficiary who resided in another county sufficient to impose equitable relief against the beneficiary, pursuant to Ga. Const. 1983, Art. VI, Sec. II, Para. III. Joinder of the beneficiary was not proper even if jurisdiction was proper as to the insurer under O.C.G.A. § 33-4-1(4) because the complaint did not seek equitable relief common to both the non-resident beneficiary and the insurer. Skaliy v. Metts, 287 Ga. 777, 700 S.E.2d 357 (2010).

Federal preemption of state law claims. — Because policies purchased by a clinic association for the benefit of doctors constituted a plan governed by the Employee Retirement Income Security Act, and the plaintiff's state law claims "related to" the plan, the state law claims (e.g., to recover benefits, bad-faith refusal to pay, and attorney fees under O.C.G.A. § 33-4-1) were preempted by 29 U.S.C. § 1144(a). Stefansson v. Equitable Life Assur. Soc'y, No. 5:04CV40 (DF), 2005 U.S. Dist. LEXIS 21723 (M.D. Ga. Sept. 19, 2005).

Paragraph (2) makes foreign insurer's liability asset of deceased insured's estate in county of place of business.

Where an owner's suit did not arise out of a title insurance company's business as an insurer, pursuant to Ga. Const. 1983, Art. VI, Sec. II, Para. III, the trial court erred in finding venue under O.C.G.A. § 33-4-1(2); in addition, the grant of an interlocutory injunction was error because there was no showing that the title company had any opportunity to challenge the applicability of an amendment to add a quiet title action under O.C.G.A. § 23-3-62 to the complaint. First Am. Title Ins. Co. v. Broadstreet, 260 Ga. App. 705, 580 S.E.2d 676 (2003).

33-4-6. Liability of insurer for damages and attorney's fees; notice to Commissioner of Insurance and consumers' insurance advocate.

(a) In the event of a loss which is covered by a policy of insurance and the refusal of the insurer to pay the same within 60 days after a demand has been made by the holder of the policy and a finding has been made that such refusal was in bad faith, the insurer shall be liable to pay such holder, in addition to the loss, not more than 50 percent of the liability of the insurer for the loss or $5,000.00, whichever is greater, and all reasonable attorney's fees for the prosecution of the action against the insurer. The action for bad faith shall not be abated by payment after the 60 day period nor shall the testimony or opinion of an expert

witness be the sole basis for a summary judgment or directed verdict on the issue of bad faith. The amount of any reasonable attorney's fees shall be determined by the trial jury and shall be included in any judgment which is rendered in the action; provided, however, the attorney's fees shall be fixed on the basis of competent expert evidence as to the reasonable value of the services based on the time spent and legal and factual issues involved in accordance with prevailing fees in the locality where the action is pending; provided, further, the trial court shall have the discretion, if it finds the jury verdict fixing attorney's fees to be greatly excessive or inadequate, to review and amend the portion of the verdict fixing attorney's fees without the necessity of disapproving the entire verdict. The limitations contained in this Code section in reference to the amount of attorney's fees are not controlling as to the fees which may be agreed upon by the plaintiff and the plaintiff's attorney for the services of the attorney in the action against the insurer.

(b) In any action brought pursuant to subsection (a) of this Code section, and within 20 days of bringing such action, the plaintiff shall, in addition to service of process in accordance with Code Section 9-11-4, mail to the Commissioner of Insurance and the consumers' insurance advocate a copy of the demand and complaint by first-class mail. Failure to comply with this subsection may be cured by delivering same. (Ga. L. 1872, p. 43, § 1; Code 1873, § 2850; Code 1882, § 2850; Civil Code 1895, § 2140; Civil Code 1910, § 2549; Code 1933, § 56-706; Code 1933, § 56-1206, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1962, p. 712, § 1; Ga. L. 2001, p. 784, § 1.)

The 2001 amendment, effective July 1, 2001, designated the existing provisions as subsection (a); in subsection (a), in the first sentence, substituted "50 percent" for "25 percent" and inserted "or $5,000.00, whichever is greater,", added the second sentence, and substituted "the plaintiff's" for "his" in the last sentence; and added subsection (b).

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2001, "consumers' insurance advocate" was substituted for "Consumers' Insurance Advocate" and "first-class mail" was substituted for "first class mail" in subsection (b).

Law reviews. — For article, "Insurance," see 53 Mercer L. Rev. 281 (2001). For article, "Bad Faith in Insurance Claim Handling in Georgia: An Overview and Update," see 9 Ga. St. B.J. 10 (2003). For annual survey of insurance law, see 56 Mercer L. Rev. 253 (2004). For survey article on insurance law, see 59 Mercer L. Rev. 195 (2007). For annual survey on insurance, see 61 Mercer L. Rev. 179 (2009). For article, "What Does ERISA Have to do with Insurance?," see 14 (No. 7) Ga. St. B.J. 19 (2009).

For note on the 2001 amendment to O.C.G.A. § 33-4-6, see 18 Ga. St. U. L. Rev. 167 (2001).

JUDICIAL DECISIONS

Analysis

General Consideration
Demand for Payment

General Consideration

Specific penalty provisions control. As an insured's counterclaim for tortious interference with a contract failed against an insurer due to the lack of evidence regarding direct inducement, the insured's counterclaims for lost profits and punitive damages that were necessarily predicated on that counterclaim failed; the counterclaims for lost profits and punitive damages were not predicated on a bad faith refusal to pay counterclaim pursuant to O.C.G.A. § 33-4-6, as the penalties provided therein were the exclusive remedies for any liability on the part of an insurer. Great Southwest Express Co. v. Great Am. Ins. Co., 665 S.E.2d 878, No. A08A0626, 2008 Ga. App. LEXIS 859, cert. denied, 293 Ga. App. 365, 667 S.E.2d 192 (2008).

Because an insurer obligated itself under the terms of its policy to pay all expenses, attorney fees and expenses constituted a "loss that was covered by the policy of insurance" within the purview of a O.C.G.A. § 33-6-4 award; the coverage under the terms of the policy, which was expressly in addition to and above the liability limits of the policy, contemplated "all expenses" in the defense of a covered suit, as well as "all reasonable expenses" incurred by the insured in assisting in the defense, which would both of necessity include attorney fees. Transp. Ins. Co. v. Piedmont Constr. Group, LLC, 301 Ga. App. 17, 686 S.E.2d 824 (2009), cert. denied, No. S10C0507, 2010 Ga. LEXIS 312 (Ga. 2010).

Construction with § 33-4-7. — Because a party mischaracterized O.C.G.A. § 33-4-7 as a "companion" to O.C.G.A. § 33-4-6 and erroneously contended that the General Assembly intended to extend the same rights to a third party, or a party other than the policy holder, and thus, the appellate court should therefore read § 33-4-7 as applying, like § 33-4-6, in the event of any covered loss, those arguments were rejected as specious. Mills v. Allstate Ins. Co., 288 Ga. App. 257, 653 S.E.2d 850 (2007).

Section provides exclusive remedy for bad faith refusal to pay.

Because the penalties contained in O.C.G.A. § 33-4-6 were the exclusive remedies for an insurer's bad faith refusal to pay insurance proceeds, attorney fees under O.C.G.A. § 13-6-11 were unavailable to an insured who prevailed on the insured's coverage claim before a jury. Johnston v. Companion Prop. & Cas. Ins. Co., 318 Fed. Appx. 861 (11th Cir. 2009) (Unpublished).

Section provides exclusive remedy for bad faith denial of benefits.

The damages set forth in O.C.G.A. § 33-4-6 are the exclusive remedy for bad faith denial of insurance benefits, so that litigation expenses under O.C.G.A. § 13-6-11 are not recoverable. Atl. Title Ins. Co. v. Aegis Funding Corp., 287 Ga. App. 392, 651 S.E.2d 507 (2007), cert. denied, 2008 Ga. LEXIS 107 (Ga. 2008).

It is exception to rule disallowing exemplary damages in contract cases.

Where the trial court found that defendant insurer was not liable to the insured since the plaintiff breached three separate conditions precedent in the policy, plaintiff's claim for bad faith penalties likewise failed. Hill v. Safeco Ins. Co. of Am., 93 F. Supp. 2d 1375 (M.D. Ga. 1999).

Insured's duty to cooperate as condition precedent. — Because the insurance policy provided that the insured had to cooperate in an investigation of a claim, but the insured refused to provide the requested financial information to the insurer after the insured's home was destroyed by fire and the insurer believed the timing was suspicious and fraudulent, the insured's suit to recover under the policy and under O.C.G.A. § 33-4-6 failed. Farmer v. Allstate Ins. Co., 396 F. Supp. 2d 1379 (N.D. Ga. Oct. 12, 2005).

Application of Erie Doctrine. — In contractor's action against the subcontractor's insurer for damages the contractor paid to the clubhouse owner resulting from the subcontractor's defective installation of windows, the district court, sitting in diversity, held that O.C.G.A. § 33-4-6 was not applicable, as it was substantive for purposes of the Erie Doctrine, and the parties agreed that the policy was governed by Florida law. Pinkerton & Law, Inc. v. Royal Ins. Co. of Am., 227 F. Supp. 2d 1348 (N.D. Ga. 2002).

Section only applies between insureds and insurers.

When an injured party sued the insurer of a motorist against whom the injured party obtained a judgment, both to collect on the judgment and to assert a claim, as assignee of the motorist, for bad faith failure to settle, while the motorist could not assign any claim the motorist might have against the insurer for a bad faith failure to settle under O.C.G.A. § 33-4-6, or any claim for punitive damages, the motorist could assign any tort claim the motorist might have had for bad faith for compensatory damages. Canal Indem. Co. v. Greene, 265 Ga. App. 67, 593 S.E.2d 41 (2003).

In an insured's suit asserting claims for bad faith breach of contract under O.C.G.A. § 33-4-6 in connection with an insurer's denial of the insured's claim for proceeds of a long-term disability insurance policy, the parent corporation of the insurer was not liable under an alter ego theory; because the insurer was not insolvent and had funds sufficient to satisfy any judgment for the insured, the insurer's corporate veil could not be pierced so as to hold the parent liable, even if the insurer and the parent failed to maintain separate corporate existences. Adams v. UNUM Life Ins. Co. of Am., 508 F. Supp. 2d 1302 (N.D. Ga. 2007).

In an insured's suit asserting claims for bad faith breach of contract under O.C.G.A. § 33-4-6 in connection with an insurer's denial of the insured's claim for proceeds of a long-term disability insurance policy, the insured's claim against the parent corporation of the insurer failed because § 33-4-6 does not provide for a separate claim against a policy administrator such as the parent. Adams v. UNUM Life Ins. Co. of Am., 508 F. Supp. 2d 1302 (N.D. Ga. 2007).

O.C.G.A. § 33-4-6 only provides for a claim against an insurer; it does not provide for a separate claim against the administrator of an insurance plan. Adams v. UNUM Life Ins. Co. of Am., 508 F. Supp. 2d 1302 (N.D. Ga. 2007).

In an insured's suit asserting claims for bad faith breach of contract under O.C.G.A. § 33-4-6 in connection with an insurer's denial of the insured's claim for proceeds of a long-term disability insurance policy, the parent corporation of the insurer, which administered the insurer's policies, was not liable under a joint venture theory because the insured's claims sounded in contract, not negligence. Adams v. UNUM Life Ins. Co. of Am., 508 F. Supp. 2d 1302 (N.D. Ga. 2007).

Bad faith attorney fees unavailable when insurer's reasons for denying coverage are not unreasonable. — Bad faith attorney fees were unavailable under O.C.G.A. § 33-4-6 based on a jury finding that an insurer wrongfully denied an insured's claim for roof damage to a commercial building caused by decayed roof trusses because the insurer's unsuccessful argument that the trusses were not "hidden from view" and that the damage could have been visually detected was not unreasonable. Johnston v. Companion Prop. & Cas. Ins. Co., 318 Fed. Appx. 861 (11th Cir. 2009) (Unpublished).

Recovery of attorney fees barred if underlying claims fail. — In an insured's suit asserting claims for breach of contract and bad faith breach of contract in connection with an insurer's denial of the insured's claim for proceeds of a disability insurance policy, the parent corporation of the insurer, which administered the insurer's policies, was not liable upon the insured's claim for attorney fees and expenses under O.C.G.A. § 33-4-6 because the insured had not succeeded on its underlying claims against the parent, which was determined not to be an alter ego of the insurer. Adams v. UNUM Life Ins. Co. of Am., 508 F. Supp. 2d 1302 (N.D. Ga. 2007).

Insurer's default insufficient to establish liability. — That a title insurer

defaulted by failing to answer the insureds' complaint did not require the trial court to award the insureds' attorney fees and penalties under O.C.G.A. § 33-4-6 because the complaint did not establish by well-pled facts, nor the fair inferences to be drawn therefrom, the insurer's liability for fees and penalties under § 33-4-6. Jimenez v. Chi. Title Ins. Co., 310 Ga. App. 9, 712 S.E.2d 531 (2011).

Cited in Burt Co. v. Clarendon Nat'l Ins. Co., 385 Fed. Appx. 892 (11th Cir. 2010) (Unpublished).

Demand for Payment

Demand for payment necessary for attorney's fees or penalty.

Since insured did not make a demand for payment before filing suit, he was not entitled to maintain a claim for bad faith penalties and attorney fees against his insurer for nonpayment of an alleged loss under a policy. Stedman v. Cotton States Ins. Co., 254 Ga. App. 325, 562 S.E.2d 256 (2002).

Standing alone, a proof of loss is not a demand for payment thereof, etc.

Due to the inadequacies of an insured's bad faith demand, as its attempt to equate the submission of a claim with the demand for payment required by O.C.G.A. § 33-4-6 was directly contravened by case law, and the fact that the insurer met all its obligations under the policy the insurer issued to its insured, the trial court did not err in denying summary judgment to the insured and granting summary judgment on the insurer's cross-motion, authorizing the insurer to quitclaim the refinanced property to the insurer in full satisfaction of its duties and obligations under the policy. BayRock Mortg. Corp. v. Chi. Title Ins. Co., 286 Ga. App. 18, 648 S.E.2d 433 (2007), cert. denied, 2008 Ga. LEXIS 108 (Ga. 2008).

Proof of loss filed after bad faith demand improper. — Bad faith claim brought by an insured against an insurer for failure to pay a claim for extra expenses incurred by the insured after the insured suffered a fire loss at one of the insured's bakeries failed because the insured made the insured's bad faith demand before the insured filed any proof of loss, and therefore, no right to demand immediate payment existed. Lavoi Corp. v. Nat'l Fire Ins. of Hartford, 293 Ga. App. 142, 666 S.E.2d 387 (2008).

Bad Faith Refusal to Pay

Exclusive remedy. — Ga. Code Ann. § 33-4-6 provided the exclusive remedy for an insurer's bad faith refusal to pay insurance proceeds. As a result, the insured had no independent claim for consequential damages, and summary judgment was granted to the insurance company on that claim. B.S.S.B., Inc. v. Owners Ins. Co., No. 7:08-CV-112 (HL), 2010 U.S. Dist. LEXIS 4106 (M.D. Ga. Jan. 20, 2010).

No recovery under section unless refusal to pay made in bad faith.

Insured was not entitled to proceeds of a business buy out expense insurance policy, because the insured was not employed full-time prior to becoming disabled and the buy out was not accomplished through the practice and pursuant to a buy-sell agreement. Oak Rd. Family Dentistry, P.C. v. Provident Life & Accident Ins. Co., 370 F. Supp. 2d 1317 (N.D. Ga. Feb. 4, 2005).

Even assuming an administratrix's original complaint was deficient for not setting forth allegations that, if proven, would have established the notice requirements to recover extra-contractual damages against a life insurance company for bad faith in denying a claim for insurance death benefits under O.C.G.A. § 33-4-6, it was clear that the administratrix's proposed amended complaint cured any defects that might have existed; thus, the administratrix adequately pleaded a breach of contract claim, including a claim for extra-contractual damages and attorney fees. Garrett v. Unum Life Ins. Co. of Am., 427 F. Supp. 2d 1158 (M.D. Ga. 2005).

Summary judgment for an insurance company on a motorist's claim against it was proper since there was no evidence of bad faith; the insurance company did not settle the motorist's property damage claim because its adjuster believed that, at the motorist's request, the motorist's insurer was assuming responsibility for settling the claim; an adjuster with the motorist's insurer confirmed that the mo-

torist's insurer had "handled" the motorist's claim, and, further, the motorist sent a demand letter to the motorist's insurer on the same day that the motorist sent a demand letter to the insurance company, indicating that the motorist was still looking to the motorist's own insurer for payment. King v. Atlanta Cas. Ins. Co., 279 Ga. App. 554, 631 S.E.2d 786 (2006).

"Acting in bad faith" in breach of contract.

Motion to dismiss a breach of contract claim against an insurer was denied because an insured could have brought a breach of contract case and a claim for bad faith refusal to pay under O.C.G.A. § 33-4-6 simultaneously. Estate of Thornton v. Unum Life Ins. Co. of Am., 445 F. Supp. 2d 1379 (N.D. Ga. 2006).

"Bad faith" in refusing to pay claim.

Facts alleged by an administratrix in the complaint, alleging an improper denial of insurance death benefits, set forth a simple claim for a breach of contract; there was no suggestion that the parties had a special relationship; absent a special relationship between parties to a contract, Georgia law did not support a tort claim for negligent infliction of emotional distress and O.C.G.A. § 33-4-6 was the administratrix's exclusive remedy. Garrett v. Unum Life Ins. Co. of Am., 427 F. Supp. 2d 1158 (M.D. Ga. 2005).

There was evidence that an insurance company that denied a claim relating to a stolen bulldozer acted in bad faith; correspondence put the company on notice of the difficulty of construing its policy. Certain Underwriters at Lloyd's of London v. Rucker Constr., Inc., 285 Ga. App. 844, 648 S.E.2d 170 (2007).

In a case wherein mortgage lenders obtained title insurance policies from an insurer to guard against defects in title, where the policies required the insurer to pay or otherwise cure the title problem in the event of such defects, and such defects clearly existed, triggering the insurer's obligations under the policies, a judgment against the insurer was upheld on appeal as it was shown that the insurer failed to comply with its obligations until after it had named its policy holders as defendants in a protracted lawsuit; the trial court was authorized to find that the lawsuit was filed by the insurer to delay or avoid legitimate claims payment. Atl. Title Ins. Co. v. Aegis Funding Corp., 287 Ga. App. 392, 651 S.E.2d 507 (2007), cert. denied, 2008 Ga. LEXIS 107 (Ga. 2008).

Trial court did not err in granting summary judgment to an insured on the issue of liability for bad faith penalties and attorney fees under O.C.G.A. § 33-4-6 because a finding of bad faith as a matter of law was eminently justified when the insurer failed to set forth any defense to a determination of bad faith other than its meritless reliance on the business-risk clauses of the insured's comprehensive general liability policy; the insurer simply submitted no admissible evidence to defend itself on the insured's bad faith claims, and the insurer neglected even to protect itself by defending under a reservation of rights while filing a declaratory judgment action in order to determine the extent of coverage and its duty to defend. Transp. Ins. Co. v. Piedmont Constr. Group, LLC, 301 Ga. App. 17, 686 S.E.2d 824 (2009), cert. denied, No. S10C0507, 2010 Ga. LEXIS 312 (Ga. 2010).

Only one penalty recoverable from one accident. — When a trial court erroneously granted an insured statutory damages against an insurer, for bad faith, under O.C.G.A. § 33-4-6, for each of 26 medical bills arising from one automobile accident, this was a nonamendable defect which appeared on the face of the record, so the trial court could correct its judgment in the term of court after the term in which the judgment was entered by granting one statutory damages award for all claims arising from the accident. Byrd v. Regal Ins. Co., 275 Ga. App. 779, 621 S.E.2d 758 (2005).

Work product documents discoverable for bad faith counterclaim. — Even though documents in an insurer's claim file were prepared in anticipation of litigation under the work product doctrine of Fed. R. Civ. P. 26(b)(3), an additional insured showed substantial need because the documents were the only reliable indication of the insurer's bad faith for the insurer's counterclaim under O.C.G.A. § 33-4-6, except that the insurer was entitled to redact information showing mental impressions. Underwriters Ins. Co. v.

Atlanta Gas Light Co., 248 F.R.D. 663 (N.D. Ga. 2008).

Insurer could dispute applicability of clause. — Trial court properly entered summary judgment for the insurer in business's bad faith claim under O.C.G.A. § 33-4-6 since there was no evidence that the insurer acted in bad faith as there was a genuine dispute as to the applicability of the civil authority clause in a business insurance policy. Assurance Co. of Am. v. BBB Serv. Co., 259 Ga. App. 54, 576 S.E.2d 38 (2002).

Declaratory judgment action must do more than ask determination of liability.

Insurer's filing of a declaratory judgment action that disputed coverage under an insured's policy did not insulate the insurer from a counterclaim filed by the insured under O.C.G.A. § 33-4-6 for bad faith refusal to pay. Great Southwest Express Co. v. Great Am. Ins. Co., 665 S.E.2d 878, No. A08A0626, 2008 Ga. App. LEXIS 859, cert. denied, 293 Ga. App. 365, 667 S.E.2d 192 (2008).

Disputed questions of fact. — To support a cause of action under O.C.G.A. § 33-4-6, the insured bears the burden of proving that the refusal to pay the claim was made in bad faith. A defense going far enough to show reasonable and probable cause for making it would vindicate the good faith of the company as effectually as would a complete defense to the action. Penalties for bad faith are not authorized where the insurance company has any reasonable ground to contest the claim and where there is a disputed question of fact. Moon v. Mercury Ins. Co., 253 Ga. App. 506, 559 S.E.2d 532 (2002).

As to the insured's claim for bad faith breach of an insurance contract under O.C.G.A. § 33-4-6, summary judgment was warranted in favor of defendants. The insurer utilized independent medical examiners (IMEs), the insurer's IMEs provided the medical bases for their conclusions; the insurer tested its IMEs' conclusions with the insured's information; and further, under Georgia law, the absence of bad faith was buttressed by the existence of a genuine issue of material fact whether defendants owed the insured coverage. Worsham v. Provident Cos., 249 F. Supp. 2d 1325 (N.D. Ga. 2003).

Refusal to pay medical benefits not unreasonable. — In accord with Jones v. State Farm Mut. Auto. Ins. Co. See Shaffer v. State Farm Mut. Auto. Ins. Co., 246 Ga. App. 244, 540 S.E.2d 227 (2000).

Suspension of payments of lost wage benefits not unreasonable. — Summary judgment on the question of plaintiff's claim for bad faith damages under subsection (a) of O.C.G.A. § 33-4-6 was proper where it was undisputed that the insurer suspended payment of plaintiff's lost wage benefits relying upon the opinion of a board certified orthopedic surgeon. Wallace v. State Farm Mut. Auto. Ins. Co., 247 Ga. App. 95, 539 S.E.2d 509 (2000).

Breach of duty to defend. — Insurer breached the insurer's duty to defend under O.C.G.A. § 33-4-6(a) against a nightclub guest's personal injury complaint; the guest's claims at least arguably would have been covered by a provision in the nightclub's insurance policy that provided coverage for an assault or battery by an employee that was committed to protect persons or property. Landmark Am. Ins. Co. v. Khan, 307 Ga. App. 609, 705 S.E.2d 707 (2011).

Refusal to pay justified at time of refusal shows no bad faith.

Given an insurer's initial and prolonged payment of disability benefits to the insured during its investigation of the insured's claim, and its eventual termination of benefits only after the insured failed to respond to inquiries requesting an explanation of how the insured's disability prevented the insured from engaging in the insured's purported occupations, the decision to terminate the benefits could not be characterized as either frivolous or unreasonable. Giddens v. Equitable Life Assur. Soc'y of the United States, 356 F. Supp. 2d 1313 (N.D. Ga. 2004), aff'd in part and rev'd in part, 445 F.3d 1286, 2006 U.S. App. LEXIS 8970 (11th Cir. Ga. 2006).

Insurer's filing of a 28 U.S.C. § 1335 interpleader suit was done in good faith as was the insurer's denial of a trustee's claim for payment of a decedent's life insurance policies as the insurer was unable to determine, due to a myriad of events that occurred between the dece-

dent's establishment of a revocable trust, whether the trust, the decedent's children with his first wife, or the decedent's second wife and any children they may have had together were entitled to the decedent's life insurance policy proceeds, and the parties were scattered through several different countries, making it more difficult for the insurer to determine who was entitled to the proceeds; that the children later averred that the proceeds belonged to the trust and the second wife disclaimed any interest in the proceeds did not mean that the insurer acted in bad faith under O.C.G.A. § 33-4-6 in denying payment of the trustee's claim. Nat'l Life Ins. Co. v. Alembik-Eisner, 582 F. Supp. 2d 1362 (N.D. Ga. 2008).

Insurance coverage demanded, but not provided. — The exclusive remedy for an insurance company's bad faith refusal to pay a claim was set forth in O.C.G.A. § 33-4-6 and penalties against the insurance company and agents were not available for their alleged bad faith as the fire insurance policy they issued to the insured did not provide the insurance coverage demanded. Anderson v. Ga. Farm Bureau Mut. Ins., 255 Ga. App. 734, 566 S.E.2d 342 (2002).

Closing protection letter not an insurance policy. — A trial court properly ruled that a mortgage lender was not entitled to statutory penalties authorized by O.C.G.A. § 33-4-6 in a suit asserting the bad faith denial on the part of a title insurance company in paying for a fraud claim as the closing protection letter relevant was not a policy of insurance so as to authorize imposition of the penalties. Lawyers Title Ins. Corp. v. New Freedom Mortg. Corp., 288 Ga. App. 642, 655 S.E.2d 269 (2007), cert. denied, 2008 Ga. LEXIS 384 (Ga. 2008).

Insured party excluded from coverage by terms of policy. — Because the driver was excluded from coverage under the insurance policy, the driver could not maintain an action for bad faith penalties and attorney fees under O.C.G.A. § 33-4-6. Progressive Ins. Co. v. Horde, 259 Ga. App. 769, 577 S.E.2d 835 (2003).

No coverage when acts intentional. — Summary judgment declaring that an insurer's liability policy did not cover an insured's liability for breach of contract and warranty resulting from sale of a defective diner was proper because the policy only covered damage caused by accidents, not intentional acts; given that there was no coverage, the insured's O.C.G.A. § 33-4-6 bad faith counterclaim necessarily failed. State Farm Fire & Cas. Co. v. Diner Concepts, Inc., No. 09-14097, 2010 U.S. App. LEXIS 5817 (11th Cir. Mar. 22, 2010).

Insured precluded damage recovery by failure to provide records to insurer. — Where insured breached insurance contract by failing to fulfill conditions precedent to commencement of suit by failing to provide insurer with any records, insured was precluded from recovery and insurer had reasonable grounds to refuse payment of the claim; accordingly, damages under O.C.G.A. § 33-4-6 were not warranted. Hall v. Liberty Mut. Fire Ins. Co., No. CV4:06-218, 2008 U.S. Dist. LEXIS 22509 (S.D. Ga. Mar. 21, 2008), aff'd, No. 08-12051, 2009 U.S. App. LEXIS 2075 (11th Cir. Ga. 2009).

Summary judgment for insurer proper on bad faith claim. — Although a worker making a claim under a disability policy was able to perform light duties, whether the worker was wholly disabled from performing "material" duties within 180 days of the injury, as required by the policy, was a jury question, and summary judgment on this issue was improper; however, the worker was not entitled to bad faith penalties under O.C.G.A. § 33-4-6 because, in light of the policy language and the underlying facts, the insurer had reasonable grounds to contest coverage for total disability. Fountain v. Unum Life Ins. Co. of Am., 297 Ga. App. 458, 677 S.E.2d 334 (2009).

Bad faith not found. — Because of an "impaired property" exclusion in a commercial general liability policy, an insurer did not breach its duty to indemnify or defend where an auto parts store filed a claim with the insurer after customers sued the store for its failure to deliver conforming goods (store allegedly filled its customers' orders for freon with a freon substitute and illegally imported freon); the court granted summary judgment in

favor of the insurer on the issues of bad faith and failure to defend and indemnify. JLM Enters., Inc. v. Houston Gen. Ins. Co., 196 F. Supp. 2d 1299 (S.D. Ga. 2002).

Insured who tried to recover damages for injuries the insured sustained in a motor vehicle accident in Florida, but who alleged that the insured's claim was denied because she did not have the right to sue under Florida's no-fault statute, was entitled to collect uninsured motorist benefits from the insured's own insurance company, pursuant to O.C.G.A. § 33-7-11. However, the trial court, which heard the insured's action against the insurance company, erred when it denied the company's motion for summary judgment on the insured's claim seeking penalties and attorney fees, pursuant to O.C.G.A. § 33-4-6, because the case presented a unique issue of law and there was no evidence that the company acted in bad faith when it denied the insured's claim. Ga. Farm Bureau Mut. Ins. Co. v. Williams, 266 Ga. App. 540, 597 S.E.2d 430 (2004).

Award in favor of an insured was reversed as the insurer refused to pay the insured's claim based on an investigation which produced evidence that the insured's claim under the policy was fraudulent. As the insured denied the fraud claim, there was a genuine conflict over whether the claim was legitimate, and since the insurer's grounds for refusing to pay the claim were reasonable and not frivolous or unfounded, there was a lack of evidence to support the jury's verdict finding that the insurer refused to pay the claim in bad faith. Allstate Ins. Co. v. Smith, 266 Ga. App. 411, 597 S.E.2d 500 (2004).

Trial court properly granted summary judgment as to the successor in interest to an insurance company as to claims of bad faith pursuant to O.C.G.A. § 33-4-6, as the insurer reasonably based its denial of coverage on a decedent's failure to make the required premium payments. Guideone Life Ins. Co. v. Ward, 275 Ga. App. 1, 619 S.E.2d 723 (2005).

Where an insurer was found to have improperly rescinded a directors and officers insurance policy with its insured, the insured was not liable for bad faith damages because the insurer's decision to rescind the policy was reasonable; the insurer promptly initiated and conducted an investigation of the circumstances surrounding the issuance of the policy, which reasonably led it to conclude that the policy had been procured on the basis of material misrepresentations. Exec. Risk Indem. v. AFC Enters., 510 F. Supp. 2d 1308 (N.D. Ga. 2007), aff'd, 279 Fed. Appx. 793 (11th Cir. 2008).

Insurer was not liable for attorney fees based on bad faith failure to pay a corporate insured's claim for inspections and repairs to faulty industrial boilers because the business risk exclusions contained in the insured's general commercial liability policy exempted such matters from recovery. Gentry Mach. Works, Inc. v. Harleysville Mut. Ins. Co., 621 F. Supp. 2d 1288 (M.D. Ga. 2008).

Insured settled a claim without its insurer's consent, contrary to a provision in the parties' policy. As the insurer was liable under the policy to pay only those sums the insured was legally obligated to pay, and neither policy provision was illegal or contrary to public policy, the insured could not sue the insurer for bad faith failure to settle, O.C.G.A. § 33-4-6, in the absence of an excess verdict or an agreed-upon settlement. Trinity Outdoor, LLC v. Cent. Mut. Ins. Co., 285 Ga. 583, 679 S.E.2d 10 (2009).

Insurance company presented evidence showing that the reason for the payment delay was because there was a dispute over how much was owed under the lost business income provision of the policy. From that evidence, the court granted the insurance company's motion for summary judgment on the insured's claim for bad faith under Ga. Code Ann. § 33-4-6. B.S.S.B., Inc. v. Owners Ins. Co., No. 7:08-CV-112 (HL), 2010 U.S. Dist. LEXIS 4106 (M.D. Ga. Jan. 20, 2010).

Trial court erred by denying an insurer's motion for summary judgment dismissing a mortgagee's claims for bad faith damages under O.C.G.A. § 33-4-6 in its action seeking payment of insurance proceeds because the insurer had good reason for delaying payment until the insurer acquired the necessary information about the foreclosure of the insured residence

less than 60 days before suit was filed; the mortgagee ultimately showed that after foreclosing on and obtaining title to the residence, the mortgagee incurred a net loss that gave the mortgagee a right to the entire $103,000 of insurance proceeds, but the information necessary for the insurer to conclude that the mortgagee had a right to claim the entire $103,000 of insurance proceeds was provided to the insurer less than 60 days before suit was filed, and the mortgagee made no demand for payment of all the insurance proceeds after that information was provided. Balboa Life & Cas., LLC v. Home Builders Fin., 304 Ga. App. 478, 697 S.E.2d 240 (2010).

Homeowner could not prevail on a bad-faith claim based on an insurer's denial of coverage for water damage to a house, as the insurer reasonably denied the claim; the policy unambiguously contained a residency requirement, and the homeowner never resided there. Mahens v. Allstate Ins. Co., No. 11-12027, 2011 U.S. App. LEXIS 22478 (11th Cir. Nov. 4, 2011) (Unpublished).

Trial court did not err in granting an insurer summary judgment on a widow's claim for bad faith penalties and attorney fees under O.C.G.A. § 33-4-6 because the insurer's reasons for refusing to pay the insurance proceeds to the widow were erroneous but not frivolous or unreasonable. Flynt v. Life of the South Ins. Co., 312 Ga. App. 430, 718 S.E.2d 343 (2011), cert. denied, 2012 Ga. LEXIS 305 (Ga. 2012).

Procedure

1. Generally

Amendment of complaint allowed. — Plaintiff insured was allowed to amend a second time to clarify a claim for a bad faith breach of an insurance contract under O.C.G.A. § 33-4-6, based on a refusal to pay disability benefits, because defendant insurers were on notice of the claim, and in fact, the parties had conducted discovery on its merits; however, the court granted the insurers leave to file a motion for summary judgment on the claim, if they chose, because briefing the issue was an efficient use of judicial resources. Worsham v. Provident Cos., 249 F. Supp. 2d 1325 (N.D. Ga. 2002).

Insured was allowed to amend the insured's complaint, which alleged that several insurers violated O.C.G.A. § 33-4-6 in the handling of the insured's claim under a homeowners' policy, so as to add claims for negligence in the handling of the insured's claim; Georgia law was ambiguous as to whether the insured could recover for negligent, as well as bad faith, failure to settle the insured's claim, and thus, the amendment was not futile. Cordell v. Pac. Indem., No. 4:05-CV-167-RLV, 2006 U.S. Dist. LEXIS 46859 (N.D. Ga. July 11, 2006).

Amount in controversy for jurisdiction. — Motion to remand was denied because the amount in controversy satisfied 28 U.S.C. § 1332 since an insurer proved by a preponderance of the evidence that the benefit payable under a life insurance policy was $51,000, which, when added with the statutory penalty of $25,500 under O.C.G.A. § 33-4-6, totaled $76,500. Estate of Thornton v. Unum Life Ins. Co. of Am., 445 F. Supp. 2d 1379 (N.D. Ga. 2006).

Bifurcation of claims proper. — Trial court was authorized to conclude, after extensive discussion with the parties, that bifurcation of an insured's breach of an insurance contract and bad faith failure to pay benefits claims were appropriate under O.C.G.A. § 9-11-42(b) because coverage turned on whether the insured's debilitating condition arose from an injury or sickness, and the discrete coverage issue had to be resolved first since bad faith was irrelevant absent coverage; even if a single action was required under O.C.G.A. § 33-4-6, nothing in the case violated the requirement because the insured brought the claims against the insurer in a single civil action, and the claims were resolved in that action, albeit through a bifurcated proceeding. Saye v. Provident Life & Accident Ins. Co., 311 Ga. App. 74, 714 S.E.2d 614 (2011), cert. denied, No. S11C1857, 2011 Ga. LEXIS 984 (Ga. 2011).

2. Burden of Proof and Evidence

Evidence held not to show bad faith.

As a title insurer did not deny coverage; hired an appraiser to evaluate the insureds' loss; and tendered the insureds a

check based on that evaluation, which the insureds' rejected, the trial court was entitled to find that the insurer did not act in bad faith. Jimenez v. Chi. Title Ins. Co., 310 Ga. App. 9, 712 S.E.2d 531 (2011).

Similar transaction evidence on failure to pay. — Trial court did not abuse the court's discretion in ruling that a widow could not introduce evidence of an insurer's conduct towards insureds in two prior cases in which the court refused to honor incontestability clauses to demonstrate bad faith because the trial court was entitled to find that the prior cases were materially dissimilar from the widow's case, given that neither of those cases involved coverage under the group policy at issue and the revisions to the certificate of insurance forms made that year. Flynt v. Life of the South Ins. Co., 312 Ga. App. 430, 718 S.E.2d 343 (2011), cert. denied, 2012 Ga. LEXIS 305 (Ga. 2012).

3. Questions for Jury or Court

Amount of penalties and attorney fees a jury question. — Trial court erred in determining the amount of bad faith penalties and attorney fees against an insured under O.C.G.A. § 33-4-6 because it was premature in determining the amount of the penalty without first submitting it to a jury as required by § 33-4-6(a). Transp. Ins. Co. v. Piedmont Constr. Group, LLC, 301 Ga. App. 17, 686 S.E.2d 824 (2009), cert. denied, No. S10C0507, 2010 Ga. LEXIS 312 (Ga. 2010).

Jury trial on attorney fees and expenses not error. — Although O.C.G.A. § 33-4-6 sets forth the exclusive remedy for bad faith denial of insurance benefits so that litigation expenses under O.C.G.A. § 13-6-11 are not recoverable, a trial court did not commit any reversible error by ordering a jury trial on issues relating only to attorney fees and not other litigation expenses. Atl. Title Ins. Co. v. Aegis Funding Corp., 287 Ga. App. 392, 651 S.E.2d 507 (2007), cert. denied, 2008 Ga. LEXIS 107 (Ga. 2008).

5. Verdict and Judgment

Award of damages in absence of finding of bad faith was error. — In a widow's suit against an insurer for failing to pay benefits under a life insurance policy, because the jury found the insurer was not guilty of bad faith in its refusal to pay these benefits but awarded the widow additional damages, the additional damages award was not authorized under O.C.G.A. § 33-4-6(a) because a finding of the insurer's bad faith was a condition precedent to such an award and there was no other authority for awarding additional damages for an insurer's failure to pay. Cherokee Nat'l Life Ins. Co. v. Eason, 276 Ga. App. 183, 622 S.E.2d 883 (2005).

Modification of order denying attorney's fees not authorized. — Where the trial court determined as a matter of law that there was no claim under an insurance policy, there could be no recovery of attorney's fees under this section, and the court was without power to modify its order denying an attorney's fees award to plaintiff after the term of court expired in which that order was made. State Farm Mut. Auto. Ins. Co. v. Johnson, 242 Ga. App. 591, 530 S.E.2d 492 (2000).

RESEARCH REFERENCES

ALR. — What constitutes bad faith on part of insurer rendering it liable for statutory penalty imposed for bad faith in failure to pay, or delay in paying, insured's claim — Particular conduct of insurer, 115 ALR5th 589.

What constitutes bad faith on part of insurer rendering it liable for statutory penalty imposed for bad faith in failure to pay, or delay in paying, insured's claim — Particular grounds for denial of claim: matters relating to policy, 116 ALR5th 247.

33-4-7. Affirmative duty to fairly and promptly adjust in incidents covered by motor vehicle liability policies; actions for bad faith; notice to Commissioner of Insurance and consumers' insurance advocate.

(a) In the event of a loss because of injury to or destruction of property covered by a motor vehicle liability insurance policy, the insurer issuing such policy has an affirmative duty to adjust that loss fairly and promptly, to make a reasonable effort to investigate and evaluate the claim, and, where liability is reasonably clear, to make a good faith effort to settle with the claimant potentially entitled to recover against the insured under such policy. Any insurer who breaches this duty may be liable to pay the claimant, in addition to the loss, not more than 50 percent of the liability of the insured for the loss or $5,000.00, whichever is greater, and all reasonable attorney's fees for the prosecution of the action.

(b) An insurer breaches the duty of subsection (a) of this Code section when, after investigation of the claim, liability has become reasonably clear and the insurer in bad faith offers less than the amount reasonably owed under all the circumstances of which the insurer is aware.

(c) A claimant shall be entitled to recover under subsection (a) of this Code section if the claimant or the claimant's attorney has delivered to the insurer a demand letter, by statutory overnight delivery or certified mail, return receipt requested, offering to settle for an amount certain; the insurer has refused or declined to do so within 60 days of receipt of such demand, thereby compelling the claimant to institute or continue suit to recover; and the claimant ultimately recovers an amount equal to or in excess of the claimant's demand.

(d) At the expiration of the 60 days set forth in subsection (c) of this Code section, the claimant may serve the insurer issuing such policy by service of the complaint in accordance with law. The insurer shall be an unnamed party, not disclosed to the jury, until there has been a verdict resulting in recovery equal to or in excess of the claimant's demand. If that occurs, the trial shall be recommenced in order for the trier of fact to receive evidence to make a determination as to whether bad faith existed in the handling or adjustment of the attempted settlement of the claim or action in question.

(e) The action for bad faith shall not be abated by payment after the 60 day period nor shall the testimony or opinion of an expert witness be the sole basis for a summary judgment or directed verdict on the issue of bad faith.

(f) The amount of recovery, including reasonable attorney's fees, if any, shall be determined by the trier of fact and included in a separate

judgment against the insurer rendered in the action; provided, however, the attorney's fees shall be fixed on the basis of competent expert evidence as to the reasonable value of the services based on the time spent and legal and factual issues involved in accordance with prevailing fees in the locality where the action is pending; provided, further, the trial court shall have the discretion, if it finds the jury verdict fixing attorney's fees to be greatly excessive or inadequate, to review and amend the portion of the verdict fixing attorney's fees without the necessity of disapproving the entire verdict. The limitations contained in this Code section in reference to the amount of attorney's fees are not controlling as to the fees which may be agreed upon by the plaintiff and his or her attorney for the services of the attorney.

(g) In any action brought pursuant to subsection (b) of this Code section, and within 20 days of bringing such action, the plaintiff shall, in addition to service of process in accordance with Code Section 9-11-4, mail to the Commissioner of Insurance and the consumers' insurance advocate a copy of the demand and complaint by first-class mail. Failure to comply with this subsection may be cured by delivering same. (Code 1981, § 33-4-7, enacted by Ga. L. 2001, p. 784, § 1.)

Effective date. — This Code section became effective July 1, 2001.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2001, a semicolon was substituted for a comma twice in subsection (c), "of this Code section" was inserted following "subsection (c)" in subsection (d), and "consumers' insurance advocate" was substituted for "Consumers' Insurance Advocate" and "first-class mail" was substituted for "first class mail" in subsection (g).

Law reviews. — For article, "Bad Faith in Insurance Claim Handling in Georgia: An Overview and Update," see 9 Ga. St. B.J. 10 (2003).

For note on the 2001 enactment of O.C.G.A. § 33-4-7, see 18 Ga. St. U. L. Rev. 167 (2001).

JUDICIAL DECISIONS

Construction with § 33-4-6. — Because a party mischaracterized O.C.G.A. § 33-4-7 as a "companion" to O.C.G.A. § 33-4-6 and erroneously contended that the General Assembly intended to extend the same rights to a third party, or a party other than the policy holder, and thus, the appellate court should therefore read § 33-4-7 as applying, like § 33-4-6, in the event of any covered loss, those arguments were rejected as specious. Mills v. Allstate Ins. Co., 288 Ga. App. 257, 653 S.E.2d 850 (2007).

Bad faith not shown. — Summary judgment for an insurance company on a motorist's claim against it was proper since there was no evidence of bad faith; the insurance company did not settle the motorist's property damage claim because its adjuster believed that, at the motorist's request, the motorist's insurer was assuming responsibility for settling the claim; an adjuster with the motorist's insurer confirmed that the motorist's insurer had "handled" the motorist's claim, and, further, the motorist sent a demand letter to the motorist's insurer on the same day that the motorist sent a demand letter to the insurance company, indicating that the motorist was still looking to the motorist's own insurer for payment. King v. Atlanta Cas. Ins. Co., 279 Ga. App. 554, 631 S.E.2d 786 (2006).

Statute applied to property, not personal injury, claims. — Because O.C.G.A. § 33-4-7 applied only to an in-

surer's bad faith in responding to claims for property damage, an insurer was properly granted a judgment on the pleadings as a complaint asserting that it acted in bad faith in responding to a claimant's claims for personal injury failed to state a claim upon which relief under the statute could be granted. Mills v. Allstate Ins. Co., 288 Ga. App. 257, 653 S.E.2d 850 (2007).

CHAPTER 5

REGULATION OF UNAUTHORIZED INSURERS

Article 2

Surplus Line Insurance

Part 1

General Provisions

Part 2

Interstate Cooperation for Collection and Disbursement of Premium Taxes

ARTICLE 1

GENERAL PROVISIONS

33-5-1. Representation of unauthorized insurers prohibited.

JUDICIAL DECISIONS

Preservation of right to raise untimely notice objection. — Surplus insurers were authorized to file a declaratory judgment action to preserve their

right to raise untimely notice of an occurrence as a defense to coverage even without a certificate of authority to conduct business in the state of Georgia. Kay-Lex Co. v. Essex Ins. Co., 286 Ga. App. 484, 649 S.E.2d 602 (2007).

ARTICLE 2

SURPLUS LINE INSURANCE

Part 1

General Provisions

Editor's notes. — Ga. L. 2011, p. 449, § 8, effective July 1, 2011, designated Code Sections 33-5-20 through 33-5-35 as Part 1 of Article 2.

33-5-20.1. Definitions.

As used in this article, the term:

(1) "Exempt commercial purchaser" means any person purchasing commercial insurance that, at the time of placement, meets the following requirements:

(A) The person employs or retains a qualified risk manager to negotiate insurance coverage;

(B) The person has paid aggregate nation-wide commercial property and casualty insurance premiums in excess of $100,000.00 in the immediately preceding 12 months; and

(C)(i) The person meets at least one of the following criteria:

(I) The person possesses a net worth in excess of $20 million as such amount is adjusted pursuant to division (ii) of this subparagraph; or

(II) The person generates annual revenues in excess of $50 million as such amount is adjusted pursuant to division (ii) of this subparagraph; or

(III) The person employs more than 500 full-time or full-time equivalent employees per individual insured or is a member of an affiliated group employing more than 1,000 employees in the aggregate;

(IV) The person is a not for profit organization or public entity generating annual budgeted expenditures of at least $30 million as such amount is adjusted pursuant to division (ii) of this subparagraph; or

(V) The person is a municipality with a population in excess of 50,000.

(ii) Effective on January 1, 2016, and every five years on January 1 thereafter, the amounts in subdivisions (I), (II), and (IV) of division (i) of this subparagraph shall be adjusted to reflect the percentage change for such five-year period in the Consumer Price Index for All Urban Consumers as reported by the Bureau of Labor Statistics of the United States Department of Labor.

(2) "Home state" means:

(A) The state in which an insured maintains its principal place of business or, in the case of an individual, the individual's principal residence; or

(B) If 100 percent of the insured risk is located outside the state referred to in subparagraph (A) of this paragraph, the state to which the greatest percentage of the insured's taxable premium for that insurance contract is allocated.

If more than one insured from an affiliated group are named insureds on a single nonadmitted insurance contract, the term "home state" means the home state, as determined according to subparagraph (A) of this paragraph, of the member of the affiliated group that has the largest percentage of premium attributed to it under such insurance contract.

(3) "Nonadmitted insurance" means any property and casualty insurance permitted in a state to be placed directly or through a surplus line broker with a nonadmitted insurer eligible to accept such insurance.

(4) "Principal place of business" means the state where the insured maintains its headquarters and where the insured's high-level officers direct, control, and coordinate the business's activities.

(5) "Principal residence" means the state where the individual resides for the greatest number of days during a calendar year.

(6) "Qualified risk manager" means, with respect to a policyholder of commercial insurance, a person who meets all of the following requirements:

(A) The person is an employee of, or third-party consultant retained by, the commercial policyholder;

(B) The person provides skilled services in purchase of insurance and in loss prevention, loss reduction, or risk and insurance coverage analysis;

(C) The person has a bachelor's degree or higher from an accredited college or university in risk management, business

administration, finance, economics, or any other field determined by a state insurance commissioner or other state regulatory official or entity to demonstrate minimum competence in risk management and:

(i) Has three years of experience in risk financing, claims administration, loss prevention, risk and insurance analysis, or purchasing commercial lines of insurance;

(ii) Has a designation as a chartered property and casualty underwriter issued by the American Institute for CPCU/Insurance Institute of America;

(iii) Has a designation as an associate in risk management issued by the American Institute for CPCU/Insurance Institute of America;

(iv) Has a designation as certified risk manager issued by the National Alliance for Insurance Education & Research;

(v) Has a designation as a RIMS Fellow issued by the Global Risk Management Institute; or

(vi) Has any other designation, certification, or license determined by the Commissioner to demonstrate minimum competency in risk management; and

(D) The person has:

(i) At least seven years of experience in risk financing, claims administration, loss prevention, risk and insurance coverage analysis, or purchasing commercial lines of insurance;

(ii) Any one of the designations specified in subparagraph (C) of this paragraph;

(iii) At least ten years of experience in risk financing, claims administration, loss prevention, risk and insurance coverage analysis, or purchasing commercial lines of insurance; or

(iv) A graduate degree from an accredited college or university in risk management, business administration, finance, economics, or any other field determined by a state insurance commissioner or other state regulatory official or entity to demonstrate minimum competence in risk management.

(7) "Surplus line insurance" means any property and casualty insurance permitted in a state to be placed through a surplus line broker with a nonadmitted insurer eligible to accept such insurance.

(8) "Surplus line broker" or "broker" means an individual who is licensed in this state to sell, solicit, or negotiate insurance on

properties, risks, or exposures located or to be performed in this state with nonadmitted insurers. (Code 1981, § 33-5-20.1, enacted by Ga. L. 2011, p. 449, § 1/HB 413.)

Effective date. — This Code section became effective July 1, 2011.

33-5-21. Authorization of procurement of surplus line insurance; conditions; procuring or placing nonadmitted insurance for exempt commercial purchaser.

(a) Surplus line insurance may be procured from unauthorized insurers subject to the following conditions:

(1) The insurance must be procured through a licensed surplus line broker;

(2) The insurance may only be procured from insurers which meet the financial condition requirements of Code Section 33-5-25;

(3) The insured or the insured's agent has made an effort to procure the desired insurance coverage or benefits from authorized insurers, but such effort has been unsuccessful in obtaining insurance coverage or benefits which are satisfactory to the insured except as provided under subsection (b) of this Code section; and

(4) The insurance shall not be procured under this chapter for personal passenger motor vehicle coverage or residential dwelling property coverage unless such insurance cannot be obtained from an authorized insurer.

(b) The broker shall not be required to make a due diligence search to determine whether the full amount or type of insurance can be obtained from authorized insurers when the surplus line broker is seeking to procure or place nonadmitted insurance for an exempt commercial purchaser, provided:

(1) The broker procuring or placing the surplus line insurance has disclosed to the exempt commercial purchaser that such insurance may be available from the admitted market that may provide greater protection with more regulatory oversight; and

(2) The exempt commercial purchaser has subsequently requested in writing for the broker to procure or place such insurance from a nonadmitted insurer. (Code 1933, § 56-614, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1992, p. 6, § 33; Ga. L. 1995, p. 1165, § 1; Ga. L. 2011, p. 449, § 2/HB 413.)

The 2011 amendment, effective July 1, 2011, designated the existing provisions of this Code section as subsection (a); added "except as provided under subsec-

tion (b) of this Code section" at the end of paragraph (a)(3); and added subsection (b).

JUDICIAL DECISIONS

Preservation of right to raise untimely notice objection. — Surplus insurers were authorized to file a declaratory judgment action to preserve their right to raise untimely notice of an occurrence as a defense to coverage even without a certificate of authority to conduct business in the state of Georgia. Kay-Lex Co. v. Essex Ins. Co., 286 Ga. App. 484, 649 S.E.2d 602 (2007).

33-5-22. Licensing of surplus line brokers generally.

A surplus lines broker shall be licensed in accordance with Code Section 33-23-37. (Code 1933, § 56-618, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1965, p. 248, § 1; Ga. L. 1973, p. 499, § 1; Ga. L. 1985, p. 1239, § 1; Ga. L. 1988, p. 1519, § 1; Ga. L. 1992, p. 2725, § 9; Ga. L. 1997, p. 683, § 1; Ga. L. 2001, p. 925, § 2.)

The 2001 amendment, effective July 1, 2002, rewrote this Code section.

33-5-25. Broker to ascertain financial condition of unauthorized insurer prior to placement of insurance therewith; placement of insurance with foreign or alien insurers.

(a) The broker shall ascertain the financial condition of the unauthorized insurer before placing insurance with the unauthorized insurer and shall not place surplus line insurance with any insurer who does not meet, according to current available reliable financial information, the requirements provided in subsection (b) of this Code section.

(b)(1) The broker shall so insure only:

(A) With an insurance company domiciled in a United States jurisdiction that is authorized to write the type of insurance in its domiciliary jurisdiction and has a capital and surplus or its equivalent under the laws of its domiciliary jurisdiction which equals the greater of:

(i) The minimum capital and surplus requirements of this title; or

(ii) Fifteen million dollars;

The requirements of this subparagraph may be satisfied by an insurer that possesses less than the minimum capital and surplus upon an affirmative finding of acceptability by the Commissioner. The finding shall be based upon such factors as quality of manage-

ment, capital and surplus of any parent company, company underwriting profit and investment income trends, market availability, and company record and reputation within the industry. In no event shall the Commissioner make an affirmative finding of acceptability when the unauthorized insurer's capital and surplus is less than $4.5 million;

(B) With any group of foreign individual underwriters licensed and domiciled in a state or United States territory if such group maintains a trust or security fund of at least $10 million as security to the full amount thereof for all policyholders and creditors in the United States of each member of the group. If the group includes incorporated and unincorporated underwriters, the incorporated members shall not be engaged in any business other than underwriting as a member of the group and shall be subject to the level of solvency regulation and control by the group's domiciliary regulatory agency as are the unincorporated members; or

(C) With an alien insurer or group of underwriters domiciled outside of the United States, including, but not limited to, any Lloyd's group, that is listed in the Quarterly Listing of Alien Insurers maintained by the International Insurers Department of the National Association of Insurance Commissioners.

(2) An insurer or group of foreign individual underwriters described in subparagraph (A) or (B) of paragraph (1) of this subsection shall annually furnish to the broker a copy of its current annual financial statement and, in the case of a group of foreign individual underwriters, evidence of compliance with required trust or security fund deposits.

(c) For any violation of this Code section, a broker's license may be suspended or revoked as provided in Code Section 33-5-23. (Code 1933, § 56-620, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1969, p. 609, § 1; Ga. L. 1985, p. 1239, § 2; Ga. L. 1989, p. 672, § 1; Ga. L. 1992, p. 6, § 33; Ga. L. 1995, p. 1165, § 2; Ga. L. 2002, p. 8, § 1; Ga. L. 2011, p. 449, § 3/HB 413; Ga. L. 2012, p. 775, § 33/HB 942.)

The 2002 amendment, effective March 11, 2002, rewrote subsection (b).

The 2011 amendment, effective July 1, 2011, rewrote subparagraph (b)(1)(A), which read: "With an insurance company licensed and domiciled in a state or United States territory which at all times maintains capital and surplus amounting to at least $3 million;"; and rewrote subparagraph (b)(1)(C), which read: "With any alien insurer or group of alien underwriters, including, but not limited to, any Lloyd's group, that is on an approved list maintained by the Commissioner."

The 2012 amendment, effective May 1, 2012, part of an Act to revise, modernize, and correct the Code, substituted "$4.5 million" for "$4,500,000.00" at the end of the undesignated text at the end of subparagraph (b)(1)(A); and substituted "the group's domiciliary regulatory agency" for "the group's domiciliary regulatory" near the end of subparagraph (b)(1)(B).

33-5-26. Endorsement of insurance contract by broker.

(a) Every insurance contract procured and delivered as a surplus line coverage shall be initialed by or bear the name of the surplus line broker who procured it and shall have printed or stamped upon it the following: "This contract is registered and delivered as a surplus line coverage under the Surplus Line Insurance Law, O.C.G.A. Chapter 33-5."

(b) No surplus lines policy or certificate in which the policy premium is $5,000.00 per annum or less shall be delivered in this state unless a standard disclosure form or brochure explaining surplus lines insurance is attached to or made a part of the policy or certificate. The Commissioner shall prescribe by rule or regulation the format and contents of such form or brochure.

(c) Pursuant to Code Section 33-2-9, the Commissioner may promulgate rules and regulations which are necessary to implement the provisions of this article. (Code 1933, § 56-616, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2002, p. 8, § 2.)

The 2002 amendment, effective March 11, 2002, designated the existing provisions as subsection (a), substituted ", O.C.G.A. Chapter 33-5" for "and this (these) insurer(s) is (are) not authorized to do business in Georgia" at the end of subsection (a), and added subsections (b) and (c).

33-5-31. Payment by broker of tax for privilege of doing business; computation and allocation of tax.

(a) The surplus line broker shall remit to the Commissioner, on or before the fifteenth day of April, July, October, and January, at the time his or her quarterly affidavit is submitted, as a tax imposed for the privilege of doing business as a surplus line broker in this state, a tax of 4 percent on all premiums paid to the surplus line broker during the preceding quarter, less return premiums and exclusive of sums collected to cover state or federal taxes, on surplus line insurance subject to tax transacted by him or her during the preceding quarter as shown by his or her affidavit filed with the Commissioner.

(b) If this state participates in a cooperative agreement, compact, or reciprocal agreement with other states pursuant to Code Sections 33-5-40 through 33-5-44 and a surplus line policy covers risks or exposures located or to be performed both in and out of this state, the sum payable shall be computed based on an amount equal to 4 percent of that portion of the gross premiums allocated to this state plus an amount equal to the portion of premiums allocated to other states or territories on the basis of the tax rates and fees applicable to properties, risks, or exposures located or to be performed outside this state. (Code 1933, § 56-623, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1972, p.

1220, § 3; Ga. L. 1974, p. 465, § 3; Ga. L. 1995, p. 1165, § 5; Ga. L. 2011, p. 449, § 4/HB 413; Ga. L. 2012, p. 1117, § 2/SB 385.)

The 2011 amendment, effective July 1, 2011, rewrote subsection (b), which read: "If a surplus line policy covers risks or exposures only partially in this state, the tax so payable shall be computed on the proportion of the premium which is properly allocable to the risks or exposures located in this state."

The 2012 amendment, effective July 1, 2012, inserted "this state participates in a cooperative agreement, compact, or reciprocal agreement with other states pursuant to Code Sections 33-5-40 through 33-5-44 and" at the beginning of subsection (b).

33-5-32. Penalty for failure to file quarterly affidavit or remit tax within time prescribed by law; collection and disposition of penalty.

If any surplus line broker fails to file his or her quarterly affidavit or fails to remit the tax as provided by law within 30 days after the tax is due, he or she shall be liable for a penalty of either $25.00 for each day of delinquency commencing after the expiration of the 30 day period or an amount equal to 100 percent of the tax, whichever is less, except that for good cause shown, the Commissioner may grant a reasonable extension of time within which the affidavit may be filed and the tax may be paid. The tax may be recovered by distraint and the penalty and tax may be recovered by an action instituted by the Commissioner in any court of competent jurisdiction. The Commissioner shall pay to the Office of the State Treasurer any penalty so collected. (Code 1933, § 56-624, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1972, p. 1220, § 4; Ga. L. 1982, p. 3, § 33; Ga. L. 1993, p. 1402, § 18; Ga. L. 2010, p. 863, § 2/SB 296; Ga. L. 2011, p. 449, § 5/HB 413.)

The 2010 amendment, effective July 1, 2010, substituted "Office of the State Treasurer" for "Office of Treasury and Fiscal Services" near the middle of the last sentence of this Code section.

The 2011 amendment, effective July 1, 2011, in the first sentence, inserted "or her", "or she", "either", and "or an amount equal to 100 percent of the tax, whichever is less".

33-5-33. Filing of report by persons procuring insurance with unauthorized insurers; levy, collection, and disposition of tax by persons procuring such insurance.

(a) Every insured who in this state procures or causes to be procured or continues or renews insurance with an unauthorized insurer upon a subject of insurance resident, located, or to be performed both within and outside this state, other than insurance procured through a surplus line broker pursuant to this article or exempted from this article under Code Section 33-5-35, shall within 30 days after the date such insurance was so procured, continued, or renewed file a report of the same with the Commissioner in writing and upon forms designated by the

Commissioner and furnished to such an insured upon request. The report shall state the name and address of the insured or insureds, name and address of the insurer, the subject of the insurance, a general description of the coverage, the amount of premium currently paid thereon, and such additional information as reasonably requested by the Commissioner.

(b) If this state participates in a cooperative agreement, compact, or reciprocal agreement with other states pursuant to Code Sections 33-5-40 through 33-5-44, then for the general support of the government of this state, there is levied and there shall be collected from every such insured in this state for the privilege of so insuring his property or interests, a tax covering risks or exposures located or to be performed both in and out of this state, after deduction of return premiums, if any. The sum payable shall be computed based upon an amount equal to 4 percent of that portion of the gross premiums allocated to this state plus an amount equal to the portion of premiums allocated to other states or territories on the basis of the tax rates and fees applicable to properties, risks, or exposures located or to be performed outside this state. Such tax shall be paid to the Commissioner coincidentally with the filing of the report provided for in subsection (a) of this Code section.

(b.1) If this state does not participate in a cooperative agreement, compact, or reciprocal agreement with other states pursuant to Code Sections 33-5-40 through 33-5-44, then for the general support of the government of this state, there is levied and there shall be collected from every such insured in this state for the privilege of so insuring his or her property or interests both in and out of this state, a tax at the rate of 4 percent of the gross premium paid for any such insurance, after deduction of return premiums, if any. Such tax shall be paid to the Commissioner coincidently with the filing of the report provided for in subsection (a) of this Code section.

(c) The tax imposed under subsection (b) of this Code section, if delinquent, shall bear interest at the rate of 6 percent per annum, compounded annually.

(d) Such tax shall be collectable by civil action brought by the Commissioner or by distraint and, if with respect to insurance of real property, the tax shall constitute a lien upon such real property while owned by the insured, enforceable in the same manner and through the same procedures as govern the collection of other taxes upon such real property under the laws of this state.

(e) This Code section shall not apply to life or accident and sickness insurances. (Code 1933, § 56-628, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2011, p. 449, § 6/HB 413; Ga. L. 2012, p. 1117, § 3/SB 385.)

The 2011 amendment, effective July 1, 2011, in subsection (a), substituted "performed both within and outside this state" for "performed within this state" in the first sentence.

The 2012 amendment, effective July 1, 2012, in subsection (b), in the first sentence, substituted "If this state participates in a cooperative agreement, compact, or reciprocal agreement with other states pursuant to Code Sections 33-5-40 through 33-5-44, then for" for "For" at the beginning, and substituted "covering risks or exposures located or to be performed both in and out of this state" for "at the rate of 4 percent of the gross premium paid for any such insurance" near the end, and added the third sentence; and added subsection (b.1).

33-5-35. Applicability of article.

This article controlling the placing of insurance with unauthorized insurers shall not apply to reinsurance or to the following insurances when so placed by licensed agents or brokers of this state:

(1) Insurance on property or operation of railroads engaged in interstate commerce; or

(2) Insurance of aircraft owned or operated by manufacturers of aircraft or operated in scheduled interstate flight, or cargo of the aircraft, or against liability, other than workers' compensation and employer's liability, arising out of the ownership, maintenance, or use of the aircraft. (Code 1933, § 56-627, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1977, p. 1281, § 2; Ga. L. 2011, p. 449, § 7/HB 413.)

The 2011 amendment, effective July 1, 2011, deleted former paragraph (1), which read: "Insurance on subjects located, resident, or to be performed wholly outside of this state or on vehicles or aircraft owned and principally garaged outside this state;"; and redesignated former paragraphs (2) and (3) as present paragraphs (1) and (2), respectively.

Part 2

Interstate Cooperation for Collection and Disbursement of Premium Taxes

Effective date. — This part became effective July 1, 2011.

33-5-40. Legislative findings.

The General Assembly finds the federal Nonadmitted and Reinsurance Reform Act of 2010, which was incorporated into the federal Dodd-Frank Wall Street Reform and Consumer Protection Act, P.L. 111-203, provides that only an insured's home state may require premium tax payment for nonadmitted insurance and authorizes states to enter into a compact or otherwise establish procedures to allocate among the states the nonadmitted insurance premium taxes. The General Assembly further finds that as the states are still in flux as to

which proposed plan is best for them to enter, or if any agreement should be entered into by the state, the Commissioner of Insurance is in a unique position to weigh these options and to determine what is in the best interest of the state financially. Therefore, the General Assembly acknowledges that some flexibility is necessary to determine that the best financial interests of the state are met. (Code 1981, § 33-5-40, enacted by Ga. L. 2011, p. 449, § 8/HB 413.)

U.S. Code. — The Dodd-Frank Wall Street Reform and Consumer Protection Act, referred to in this Code section, is codified at 12 U.S.C. § 5381 et seq.

33-5-41. Governor authorized to enter into cooperative agreement, compact, or reciprocal agreement for collection of insurance premium taxes.

The Governor, on behalf of the state, advised by and in consultation with the Commissioner of Insurance, is authorized to enter into a cooperative agreement, compact, or reciprocal agreement with another state or states for the purpose of the collection of insurance premium taxes imposed by Code Sections 33-5-31 and 33-5-33. (Code 1981, § 33-5-41, enacted by Ga. L. 2011, p. 449, § 8/HB 413; Ga. L. 2012, p. 1117, § 4/SB 385.)

The 2012 amendment, effective July 1, 2012, substituted "Code Sections 33-5-31 and 33-5-33" for "Code Section 33-5-31" in this Code section.

33-5-42. Agreement to substantially follow form of model Surplus Lines Insurance Multi-State Compliance Compact.

The cooperative agreement, compact, or reciprocal agreement for the purpose of the collection of insurance premiums imposed by Code Section 33-5-31 shall substantially follow the form of the model Surplus Lines Insurance Multi-State Compliance Compact, also known as SLIMPACT-lite, created by the National Conference of Insurance Legislators or the model Nonadmitted Insurance Multi-State Agreement, also known as NIMA, created by the National Association of Insurance Commissioners, as such documents exist on July 1, 2011. (Code 1981, § 33-5-42, enacted by Ga. L. 2011, p. 449, § 8/HB 413.)

33-5-43. Governor to select agreement providing best financial advantage.

The Governor with the consultation and advice of the Commissioner shall select the agreement, if any, that provides the best financial advantage to the state. In determining which agreement, if any, provides the best financial advantage to the state, the Governor with the consultation and advice of the Commissioner shall consider the

impact on the state's gross receipt of premium tax, the potential additional administrative burden to the state and surplus line brokers procuring or placing surplus line insurance under this chapter, and such other criteria as determined by the Governor with the consultation and advice of the Commissioner. (Code 1981, § 33-5-43, enacted by Ga. L. 2011, p. 449, § 8/HB 413.)

33-5-44. Notice; report.

In the event the Governor enters into a cooperative agreement, compact, or reciprocal agreement with another state or states as authorized under this part, notice of such action shall be communicated to the chairperson of the House Committee on Insurance and the chairperson of the Senate Insurance and Labor Committee. The Commissioner shall thereafter annually issue a report to such committees that assesses whether, in his or her opinion, the agreement continues to be in the best financial interest of the state. (Code 1981, § 33-5-44, enacted by Ga. L. 2011, p. 449, § 8/HB 413.)

CHAPTER 6

UNFAIR TRADE PRACTICES

Article 1

General Provisions

ARTICLE 1

GENERAL PROVISIONS

33-6-1. Purpose of article.

JUDICIAL DECISIONS

Unfair insurance practices not subject to Georgia's Uniform Deceptive Trade Practices Act. — Pursuant to O.C.G.A. § 10-1-374(a)(1), insurance transactions are exempt from Georgia's Uniform Deceptive Trade Practices Act (UDTPA), O.C.G.A. § 10-1-370 et seq. Claims of unfair trade practices in insurance transactions are instead governed by the Georgia Insurance Code. Northeast Ga. Cancer Care, LLC v. Blue Cross & Blue Shield of Ga., Inc., 297 Ga. App. 28, 676 S.E.2d 428 (2009), cert. denied, No. S09C1241, 2009 Ga. LEXIS 805 (Ga. 2009).

Cited in Fairfax MK, Inc. v. City of Clarkston, 274 Ga. 520, 555 S.E.2d 722 (2001).

33-6-4. Enumeration of unfair methods of competition and unfair or deceptive acts or practices; penalty.

(a) As used in this Code section, the term "policy" means any insuring bond issued by an insurer.

(b) The following acts or practices are deemed unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:

(1) Making, publishing, disseminating, circulating, or placing before the public or causing directly or indirectly to be made, published, disseminated, circulated, or placed before the public in a newspaper, magazine, or other publication or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio station or in any other way an advertisement, announcement, or statement containing any assertion, representation, or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business, which statement, assertion, or representation is untrue, deceptive, or misleading;

(2) Making, issuing, circulating, or causing to be made, issued, or circulated any estimate, illustration, circular, or statement misrepresenting the terms of any policy issued or to be issued, the benefits or advantages promised thereby, or the dividends or share of the surplus to be received thereon; making any false or misleading statement as to the dividends or share of surplus previously paid on similar policies; making any misleading representation or any misrepresentation as to the financial condition of any insurer, as to the legal reserve system upon which any life insurer operates; using any name or title of any policy or class of policies misrepresenting the true nature thereof; or making any misrepresentation to any policyholder insured in any company for the purpose of inducing or tending to induce the policyholder to lapse, forfeit, or surrender his insurance. A dividend estimate prepared on company forms and clearly indicating, in type equal in size to that used in figures showing amounts of estimated dividends, that the dividends are based on estimates made by the company based upon past experience of the company shall not be considered misrepresentation and false advertising within the meaning of this paragraph;

(3) Making, publishing, disseminating, or circulating directly or indirectly or aiding, abetting, or encouraging the making, publishing, disseminating, or circulating of any oral or written statement or any pamphlet, circular, article, or literature which is false or maliciously critical of or substantially misrepresents the financial condition of an insurer and which is calculated to injure any person engaged in the business of insurance;

(4) Entering into any agreement to commit or by any concerted action committing any act of boycott, coercion, or intimidation resulting in or tending to result in unreasonable restraint of or monopoly in the business of insurance;

(5) Filing with any supervisory or other public official or making, publishing, disseminating, circulating, delivering to any person, or placing before the public or causing directly or indirectly to be made, published, disseminated, circulated, delivered to any person, or placed before the public any false statement of financial condition of an insurer with the intent to deceive;

(6) Making any false entry in any book, report, or statement of any insurer with intent to deceive any agent or examiner lawfully appointed to examine into its condition or into any of its affairs or any public official to whom such insurer is required by law to report or who has authority by law to examine into its condition or into any of its affairs or, with like intent, willfully omitting to make a true entry of any material fact pertaining to the business of such insurer in any book, report, or statement of the insurer;

(7) Issuing or delivering or permitting agents, officers, or employees to issue or deliver agency or company stock or other capital stock, benefit certificates or shares in any common-law corporation, securities, or any special or advisory board contracts of any kind promising returns and profits as an inducement to insurance;

(8)(A)(i) Making or permitting any unfair discrimination between individuals of the same class, same policy amount, and equal expectation of life in the rates charged for any contract of life insurance or of life annuity, in the dividends or other benefits payable thereon, or in any other of the terms and conditions of the contract.

(ii) Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of accident or sickness insurance, in the benefits payable thereunder, in any of the terms or conditions of the contract, or in any other manner whatever.

(iii) Making or permitting any unfair discrimination in the issuance, renewal, or cancellation of any policy or contract of insurance against direct loss to residential property and the contents thereof, in the amount of premium, policy fees, or rates charged for the policies or contracts when the discrimination is based solely upon the age or geographical location of the property within a rated fire district without regard to objective loss experience relating thereto.

(iv)(I) Unfair discrimination prohibited by the provisions of this subparagraph includes discrimination based on race, color, and national or ethnic origin. In addition, in connection with any kind of insurance, it shall be an unfair and deceptive act or practice to refuse to insure or to refuse to continue to insure an individual; to limit the amount, extent, or kind of coverage available to an individual; or to charge an individual a different rate for the same coverage because of the race, color, or national or ethnic origin of that individual. The prohibitions of this division are in addition to and supplement any and all other provisions of Georgia law prohibiting such discrimination which were previously enacted and currently exist, or which may be enacted subsequently, and shall not be a limitation on such other provisions of law.

(II) A violation of this division shall give rise to a civil cause of action for damages resulting from such violation including, but not limited to, all damages recoverable for breach of insuring agreements under Georgia law including damages for bad faith and attorney's fees and costs of litigation. A violation of this division shall also give rise to the awarding of punitive or exemplary damages in an amount as may be determined by the trier of fact if such violation is found to be intentional. The remedies provided in this division are in addition to and cumulative of all other remedies that may now or hereafter be provided by law.

(B) Knowingly permitting or offering to make or making any contract of insurance or agreement as to the contract other than as plainly expressed in the contract issued thereon; paying, allowing, giving, or offering to pay, allow, or give directly or indirectly, as inducement to any contract of insurance, any rebate of premiums payable on the contract, any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract, except in accordance with an applicable rate filing, rating plan, or rating system filed with and approved by the Commissioner; giving, selling, purchasing, or offering to give, sell, or purchase as inducement to such insurance or in connection therewith any stocks, bonds, or other securities of any company, any dividends or profits accrued thereon, or anything of value whatsoever not specified in the contract; or receiving or accepting as inducement to contracts of insurance any rebate of premium payable on the contract, any special favor or advantage in the dividends or other benefit to accrue thereon, or any valuable consideration or inducement not specified in the contract.

(C) Nothing in subparagraphs (A) and (B) of this paragraph shall be construed as including within the definition of discrimination or rebates any of the following practices:

(i) In the case of any contract of life insurance or life annuity, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance, provided that any bonuses or abatement of premiums shall be fair and equitable to policyholders and for the best interest of the company and its policyholders;

(ii) In the case of life or accident and sickness insurance policies issued on the industrial debit or weekly premium plan, making allowance in an amount which fairly represents the saving in collection expense to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer;

(iii) Making a readjustment of the rate of premium for a policy based on the loss or expense experienced at the end of the first or any subsequent policy year of insurance thereunder, which adjustment may be made retroactive only for the policy year;

(iv) Issuing life or accident and sickness insurance policies covering bona fide employees of the insurer at a rate less than the rate charged other persons in the same class;

(v) Issuing life or accident and sickness policies on a salary-saving, payroll deduction, preauthorized, postdated, automatic check, or draft plan at a reduced rate commensurate with the savings made by the use of such plan;

(vi) Paying commissions or other compensation to duly licensed agents or brokers or allowing or returning dividends, savings, or unabsorbed premium deposits to participating policyholders, members, or subscribers;

(vii) Paying by an insurance agent of part or all of the commissions on public insurance to a nonprofit association of insurance agents which is affiliated with a recognized state or national insurance agents' association, which commissions are to be used in whole or in part for one or more civic enterprises;

(viii) Paying for food or refreshments by an insurer or an agent, broker, or employee of an insurer for current or prospective clients during group sales presentations and group seminars, provided that no insurance or annuity applications or contracts are offered or accepted at such presentations or seminars; or

(ix) Paying for business meals and entertainment by an insurer or an agent, broker, or employee of an insurer, agent, or broker for current or prospective clients;

(9) Failing to instruct and require properly that agents shall, in the solicitation of insurance and the filling out of applications of insurance on behalf of policyholders, incorporate therein all material facts relevant to the risk being written, which facts are known to the agent or could have been known by proper diligence;

(10) Encouraging agents to accept applications which contain material misrepresentations or conceal material information which, if stated in the application, would prevent issuance of the policy or which would void a policy from its inception according to its terms even though premiums had been paid on the policy;

(11) Any insurer or agent of same becoming a party to requiring or imposing as a condition to the sale of real or personal property or to the financing of real or personal property, as a condition to the granting of or an extension of a loan which is to be secured by the title to or a lien of any kind on real or personal property, or as a condition to the performance of any other act in connection with the sale, financing, or lending, whether the person thus acts for himself or for anyone else, that the insurance or any renewal thereof to be issued on said property as collateral to said sale or loan shall be written through any particular insurance company or agent, provided that this paragraph shall not apply to a policy purchased by the seller, financier, or lender from his or its own funds and not charged to the purchaser or borrower in the sale price of the property or the amount of the loan or required to be paid for out of his personal funds; provided, further, that such seller, financier, or lender may disapprove for reasons affecting solvency or other sensible and sufficient reasons, the insurance company selected by the buyer or borrower. This paragraph shall not apply to title insurance;

(12)(A) Representing that any insurer or agent is employed by or otherwise associated with any medicare program as defined in Code Section 33-43-1 or the United States Social Security Administration or that any insurance policy sold or offered for sale has been endorsed or sponsored by the federal or state government.

(B) Knowingly selling or offering to sell medicare supplement insurance coverage as defined in Code Section 33-43-1 which is not in compliance with the provisions of Chapter 43 of this title, relating to medicare supplement insurance, or the rules and regulations promulgated by the Commissioner pursuant to Chapter 43 of this title.

(C) Representing that any individual policy is a group policy or that the insurer, agent, or policy is endorsed, sponsored by, or

associated with any group, association, or other organization unless such is, in fact, the case.

(D) Knowingly selling to Medicaid recipients substantially unnecessary coverage which duplicates benefits provided under the Medicaid program without disclosing to the prospective buyer that it may not be to the buyer's benefit or that it might actually be to the buyer's detriment to purchase the additional coverage;

(13)(A) Making direct response advertising by an insurer, including radio or television advertisement, of any individual or group life insurance policy in which computation of the death benefit is of such a technical nature that such death benefit cannot reasonably be properly presented in the advertisement and understood by a member of the insuring public. Policies, other than variable life or other interest sensitive policies, which provide for multiple changes in death benefits, combinations of increasing and nonuniformly decreasing term insurance, or increasing life insurance benefits equal to or slightly greater than the premiums paid during the early years of the coverage combined with accidental death benefits are types of contracts within the purview of this subparagraph. Additionally, any life insurance policy which cannot be truthfully, completely, clearly, and accurately disclosed in an advertisement falls within this subparagraph.

(B) Making direct response advertising by an insurer, including radio or television advertisement, of any individual or group accident and sickness or life insurance policy which is misleading in fact or by implication that the coverage is "guaranteed issue" when there are conditions to be met by those persons to be insured, such as limited medical questions or other underwriting guidelines of the insurer.

(C) Making direct response advertising by an insurer, including radio or television advertisement, of any individual or group accident and sickness or life insurance policy where such advertisement has not been approved for use in this state by the Commissioner of Insurance;

(14) Failing to disclose in printed advertising material that medical benefits are calculated on the basis of usual, customary, and reasonable charges;

(14.1) Engaging in dishonest, unfair, or deceptive insurance practices in marketing or sales of insurance to service members of the armed forces of the United States and, notwithstanding any other provision of this title, the Commissioner may promulgate such rules and regulations as necessary to define dishonest, unfair, or deceptive military marketing and sales practices; or

(15)(A) As used in this paragraph:

(i) "Confidential family violence information" means information about acts of family violence, the status of a victim of family violence, an individual's medical condition that the insurer knows or has reason to know is related to family violence, or the home and work addresses and telephone numbers of a subject of family violence.

(ii) "Family violence" means family violence as defined in Code Sections 19-13-1 and 19-13-20 and as limited by Code Section 19-13-1.

(B) No person shall deny or refuse to accept an application; refuse to insure; refuse to renew; refuse to reissue; cancel, restrict, or otherwise terminate; charge a different rate for the same coverage; add a premium differential; or exclude or limit coverage for losses or deny a claim incurred by an insured on the basis that the applicant or insured is or has been a victim of family violence or that such person knows or has reason to know the applicant or insured may be a victim of family violence; nor shall any person take or fail to take any of the aforesaid actions on the basis that an applicant or insured provides shelter, counseling, or protection to victims of family violence.

(C) No person shall request, directly or indirectly, any information the person knows or reasonably should know relates to acts of family violence or an applicant's or insured's status as a victim of family violence or make use of such information however obtained, except for the limited purpose of complying with legal obligations, verifying an individual's claim to be a subject of family violence, cooperating with a victim of family violence in seeking protection from family violence, or facilitating the treatment of a family violence related medical condition. When a person has information in their possession that clearly indicates that the insured or applicant is a subject of family violence, the disclosure or transfer of the information by a person to any person, entity, or individual is a violation of this Code section, except:

(i) To the subject of abuse or an individual specifically designated in writing by the subject of abuse;

(ii) To a health care provider for the direct provision of health care services;

(iii) To a licensed physician identified and designated by the subject of abuse;

(iv) When ordered by the Commissioner or a court of competent jurisdiction or otherwise required by law;

(v) When necessary for a valid business purpose to transfer information that includes family violence information that cannot reasonably be segregated without undue hardship. Family violence information may be disclosed pursuant to this division only to the following persons or entities, all of whom shall be bound by this subparagraph:

(I) A reinsurer that seeks to indemnify or indemnifies all or any part of a policy covering a subject of abuse and that cannot underwrite or satisfy its obligations under the reinsurance agreement without that disclosure;

(II) A party to a proposed or consummated sale, transfer, merger, or consolidation of all or part of the business of the person;

(III) Medical or claims personnel contracting with the person, only where necessary to process an application or perform the person's duties under the policy or to protect the safety or privacy of a subject of abuse; or

(IV) With respect to address and telephone number, to entities with whom the person transacts business when the business cannot be transacted without the address and telephone number;

(vi) To an attorney who needs the information to represent the person effectively, provided the person notifies the attorney of its obligations under this paragraph and requests that the attorney exercise due diligence to protect the confidential abuse information consistent with the attorney's obligation to represent the person;

(vii) To the policy owner or assignee, in the course of delivery of the policy, if the policy contains information about abuse status; or

(viii) To any other entities deemed appropriate by the Commissioner.

(D) It is unfairly discriminatory to terminate group coverage for a subject of family violence because coverage was originally issued in the name of the perpetrator of the family violence and the perpetrator has divorced, separated from, or lost custody of the subject of family violence, or the perpetrator's coverage has terminated voluntarily or involuntarily. If termination results from an act or omission of the perpetrator, the subject of family violence shall be deemed a qualifying eligible individual under Code Section 33-24-21.1 and may obtain continuation and conversion of such coverages notwithstanding the act or omission of the perpetrator. A

person may request and receive family violence information to implement the continuation and conversion of coverages under this subparagraph.

(E) Subparagraph (C) of this paragraph shall not preclude a subject of family violence from obtaining his or her insurance records. Subparagraph (C) of this paragraph shall not prohibit a person from asking about a medical condition or a claims history or from using medical information or a claims history to underwrite or to carry out its duties under the policy to the extent otherwise permitted under this paragraph and other applicable law.

(F) No person shall take action that adversely affects an applicant or insured on the basis of a medical condition, claim, or other underwriting information that the person knows or has reason to know is family violence related and which:

(i) Has the purpose or effect of treating family violence status as a medical condition or underwriting criterion;

(ii) Is based upon correlation between a medical condition and family violence;

(iii) Is not otherwise permissible by law and does not apply in the same manner and to the same extent to all applicants and insureds similarly situated without regard to whether the condition or claim is family violence related; or

(iv) Except for claim actions, is not based on a determination, made in conformance with sound actuarial and underwriting principles and guidelines generally applied in the insurance industry and supported by reasonable statistical evidence, that there is a correlation between the applicant's or insured's circumstances and a material increase in insurance risk.

(G) No person shall fail to pay losses arising out of family violence against an innocent first-party claimant to the extent of such claimant's legal interest in the covered property, if the loss is caused by the intentional act of an insured against whom a family violence complaint is brought for the act causing this loss.

(H) No person shall use other exclusions or limitations on coverage which the Commissioner has determined through the policy filing and approval process to unreasonably restrict the ability of victims of family violence to be indemnified for such losses.

(I) Any person issuing, delivering, or renewing a policy of insurance in this state at any time within a period of 24 months after July 1, 2000, shall include with such policy or renewal

certificate a notice attached thereto containing the following language:

"NOTICE

The laws of the State of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family violence."

(c) Any person violating this Code section by making unlawful, false representations as to the policy sold shall be guilty of a misdemeanor. (Code 1933, §§ 56-704, 56-9906, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1978, p. 2016, § 1; Ga. L. 1980, p. 1266, § 2; Ga. L. 1989, p. 888, § 1; Ga. L. 1989, p. 1276, § 1; Ga. L. 1992, p. 6, § 33; Ga. L. 1992, p. 996, §§ 1-3; Ga. L. 2000, p. 236, § 1; Ga. L. 2001, p. 4, § 33; Ga. L. 2002, p. 441, § 2; Ga. L. 2005, p. 563, § 2/HB 407; Ga. L. 2006, p. 72, § 33/SB 465; Ga. L. 2006, p. 433, § 1/HB 425; Ga. L. 2007, p. 500, § 1/SB 84.)

The 2001 amendment, effective February 12, 2001, part of an Act to revise, modernize, and correct the Code; in subsection (b), redesignated division (b)(15)(A)(i) and division (b)(15)(A)(ii) as division (b)(15)(A)(ii) and division (b)(15)(A)(i), respectively.

The 2002 amendment, effective July 1, 2002, added division (b)(8)(A)(iv). See editor's notes for applicability.

The 2005 amendment, effective July 1, 2005, added division (b)(8)(C)(viii).

The 2006 amendments. — The first 2006 amendment, effective April 14, 2006, part of an Act to revise, modernize, and correct the Code, substituted "sales presentations and seminars, provided that" for "sales presentations and seminars provided that" near the middle of division (b)(8)(C)(viii). The second 2006 amendment, effective July 1, 2006, in subdivision (b)(8)(C)(viii), inserted "group" in two places, and added "or" at the end; and added subdivision (b)(8)(C)(ix).

The 2007 amendment, effective July 1, 2007, deleted "or" at the end of paragraph (b)(14); and added paragraph (b)(14.1).

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2002, in subdivision (b)(8)(A)(iv)(II), "this division" was substituted for "this Code section" in the second sentence and "in this division" was substituted for "herein" in the last sentence.

Editor's notes. — Ga. L. 2002, p. 441, § 1, not codified by the General Assembly, provides that: "This Act shall be known and may be cited as the 'Consumers' Health Insurance Protection Act.'"

Ga. L. 2002, p. 441, § 11, not codified by the General Assembly, provides that: "This Act shall apply only to health benefit plan contracts issued, delivered, issued for delivery, or renewed in this state on or after October 1, 2002; provided, however, that Section 8 of this Act shall apply to all claims relating to health care services provided on or after July 1, 2002. Any carrier, plan, network, panel, or agent thereof conducting a post-payment audit or imposing a retroactive denial on any claim initially submitted prior to July 1, 2002, shall, no later than June 30, 2003, provide written notice to the claimant of the intent to conduct such an audit or impose such a retroactive denial of any such claim or part thereof, including the specific reason for the audit or denial and shall complete the audit or retroactive denial and provide notice to the claimant of any payment or refund due prior to January 1, 2004." The reference to Section 8 of the Act apparently should be to Section 9 of the Act, which enacted Article 3 of Chapter 20A of this title.

Law reviews. — For note on 1989 amendment to this Code section, see 6 Ga. St. U. L. Rev. 261 (1989). For note on the 2002 amendment of this section, see 19 Ga. St. U. L. Rev. 220 (2002).

JUDICIAL DECISIONS

Cited in Nat'l Viatical, Inc. v. State, 258 Ga. App. 408, 574 S.E.2d 337 (2002); Fortis Ins. Co. v. Kahn, 299 Ga. App. 319, 683 S.E.2d 4 (2009).

33-6-5. Other unfair methods of competition and unfair and deceptive acts or practices.

In addition to Code Section 33-6-4, violations of the following provisions also are defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:

(1) No insurance company shall issue or cause to be issued any policy of insurance of any type or description upon life or property, real or personal, whenever such policy of insurance is to be furnished or delivered to the purchaser or bailee of any property, real or personal, as an inducement to purchase or bail such property, real or personal; and no other person shall advertise, offer, or give free insurance or insurance without cost or for less than the approved or customary rate in connection with the sale or bailment of real or personal property, except as provided in Chapter 27 of this title;

(2) No person who is not an insurer shall assume or use any name which deceptively implies or suggests that he or she is an insurer;

(3) Where the premium or charge for insurance of or involving real or personal property or merchandise is included in the overall purchase price or financing of the purchase of merchandise or property, the vendor or lender shall separately state and identify the amount charged and to be paid for the insurance and the classifications, if any, upon which based; and the inclusion or exclusion of the cost of insurance in such purchase price or financing shall not increase, reduce, or otherwise affect any other factor involved in the cost of the merchandise or property or financing as to the purchaser or borrower. A vendor or lender shall not be prohibited from charging the purchaser or borrower a finance charge otherwise permitted by law on any premium or charge for insurance included in the cost of the merchandise or property or financing. This paragraph shall not apply to credit life or credit accident and sickness insurance which is in compliance with Code Section 33-31-7;

(4)(A) No insurer shall make, offer to make, or permit any preference or distinction in property, marine, casualty, or surety insurance as to form of policy, certificate, premium, rate, or conditions of insurance based upon membership, nonmembership, or employment of any person or persons by or in any particular group, association, corporation, or organization, making the foregoing preference or distinction available in any event based upon any fictitious grouping of persons.

(B) As used in this paragraph, the term "fictitious grouping" means any grouping by way of membership, nonmembership, license, franchise, employment contract, agreement, or any other method or means resulting in unfair discrimination.

(C) The restrictions and limitations of this paragraph shall not extend to life or accident and sickness insurance; nor shall they apply to any bona fide association group which is composed of members engaged in a common trade, business, or profession and which has had group insurance of the same type continuously in existence for at least five years immediately preceding March 8, 1960;

(5) No insurer or agent thereof shall hypothecate, sell, or dispose of a promissory note received in payment of any part of a premium on a policy of insurance applied for prior to acceptance of the risk by the insurer;

(6)(A) No person shall knowingly collect any sum as premium or charge for insurance, which insurance is not then provided or not in due course to be provided subject to acceptance of the risk by the insurer by an insurance policy issued by an insurer as permitted by this title.

(B) No person shall knowingly collect as premium or charge for insurance any sum in excess of or less than the premium or charge applicable to such insurance, which sum is specified in the policy in accordance with the applicable classifications and rates as filed with and approved by the Commissioner. In cases where classifications, premiums, or rates are not required by this title to be filed and approved:

(i) The premiums and charges for insurance, except insurance written in accordance with Chapter 5 of this title, shall not be in excess of or less than those specified in the policy and as fixed by the insurer; and

(ii) The premiums and charges for insurance written in accordance with Chapter 5 of this title shall not be in excess of or less than those specified in the policy.

This subparagraph shall not be deemed to prohibit surplus lines brokers licensed under Chapter 5 of this title from charging and collecting the amount of applicable state and federal taxes in addition to the premium required by the insurer; nor shall it be deemed to prohibit a life or accident and sickness insurer from charging and collecting amounts actually to be expended for medical examination of an applicant for life or accident and sickness insurance or for reinstatement of a life or accident and sickness insurance policy.

(C) Notwithstanding this paragraph or any other law limiting or regulating interest rates or other charges, any insurance agent or agency, as defined in Code Section 33-23-1, shall be authorized but not required to charge, receive, and collect on any unpaid premium account with a balance owing for 30 days or more a service charge which shall not exceed 15¢ per $10.00 per month computed on all amounts unpaid on the premium from month to month which need not be a calendar month or other regular period; provided, however, that, if the amount of service charge so computed shall be less than $1.00 for the month, a service charge of $1.00 for the month may be charged, received, and collected. Nothing contained in this subparagraph shall be construed to prevent an agent, agency, or broker from canceling a policy in accordance with the laws of this state;

(7)(A) Any insurer may retain, invest in, or acquire the whole or any part of the capital stock of any other insurer or insurers or have a common management with any other insurer or insurers, unless such retention, investment, acquisition, or common management is inconsistent with any other provision of this title or unless, by reason thereof, the business of such insurers with the public is conducted in a manner which substantially lessens competition generally in the insurance business or tends to create a monopoly therein.

(B) Any person otherwise qualified may be a director of two or more insurers which are competitors, unless the effect thereof is to lessen substantially competition between insurers generally or tends materially to create a monopoly;

(8) No insurance company shall cancel, modify coverage, refuse to issue, or refuse to renew any property or casualty insurance policy solely because the applicant or insured or any employee of either is mentally or physically impaired, provided that this paragraph shall not apply to accident and sickness insurance policies sold by a casualty insurer; provided, further, that this paragraph shall not be interpreted to modify any other provision of this title relating to the cancellation, modification, issuance, or renewal of any insurance policy or contract;

(9) No insurance company, when selling salvage motor vehicles, major component parts, or parts, shall sell directly to a used motor vehicle parts dealer, motor vehicle dismantler, motor vehicle rebuilder, salvage pool dealer, or salvage dealer who is not licensed under Chapter 47 of Title 43; provided, however, this paragraph shall not prevent an insurance company from selling salvage motor vehicles, major component parts, or parts to any person, firm, or corporation when the sale is made through a used motor vehicle parts dealer, motor vehicle dismantler, motor vehicle rebuilder, salvage

pool dealer, or salvage dealer who is licensed under Chapter 47 of Title 43;

(10) No insurer shall refuse to insure an individual, refuse to continue to insure an individual, limit the amount, extent, or kind of coverage available to an individual, or charge an individual a different rate for coverage solely because the individual is blind or partially blind;

(11) Each insurer which acquires a salvage motor vehicle, as defined in Code Section 40-3-2, shall, within 30 days of acquisition, apply for a salvage certificate of title, and no insurer shall sell, convey, or transfer any such salvage motor vehicle without first applying for and obtaining a salvage certificate of title;

(12)(A) No insurer shall cancel, nonrenew, or otherwise terminate all or substantially all of an entire line or class of business for the purpose of withdrawing from the market in this state unless:

(i) The insurer has notified the Commissioner in writing of the action, including the reasons for such action, at least one year before the completion of the withdrawal, provided that this paragraph shall not be construed to prevent such insurer from canceling, nonrenewing, or terminating policies where the insurer, by contract, statute, or otherwise, has the right to do so; or

(ii) The insurer has filed a plan of action for the orderly cessation of the insurer's business within a period of time shorter than one year and such plan of action has been approved by the Commissioner.

(B) At a minimum, in order to provide for orderly cessation and withdrawal, an insurer shall provide a general notice to each insured at least 90 days prior to the termination of any policy followed by a subsequent notice which meets the applicable statutory notice requirements for canceling, nonrenewing, or terminating insurance under this title.

(C) An insurer's rates, rules, and forms filed pursuant to Code Sections 33-9-21 and 33-24-9 shall be considered no longer on file for use with any new business in the market affected by the insurer's withdrawal plan on and after the withdrawal plan goes into effect;

(12.1) No insurer or managed care entity subject to licensing by the Commissioner shall violate any provision of Chapter 20A of this title;

(13)(A) As used in this paragraph, the term:

(i) "Aftermarket crash part" means a replacement for any of the nonmechanical sheet metal or plastic parts which generally

constitute the exterior of a motor vehicle, including inner and outer panels.

(ii) "Insurer" includes an insurance company and any person authorized to represent the insurer with respect to a claim and who is acting within the scope of the person's authority.

(iii) "Nonoriginal equipment manufacturer aftermarket crash part" means an aftermarket crash part made by any manufacturer other than the original vehicle manufacturer or his or her supplier.

(iv) "Repair facility" means a motor vehicle dealer, garage, body shop, or other commercial entity which undertakes the repair or replacement of those parts that generally constitute the exterior of a motor vehicle.

(B) Any aftermarket crash part manufactured or supplied for use in this state on or after January 1, 1990, shall have affixed thereto or inscribed thereon the logo, identification number, or name of its manufacturer. Such manufacturer's logo, identification number, or name shall be visible after installation whenever practicable.

(C) In all instances where nonoriginal equipment manufacturer aftermarket crash parts are used in preparing an estimate for repairs the written estimate prepared by the insurance adjuster and repair facility shall clearly identify each such part. A disclosure document attached to the estimate shall contain the following information in no smaller than ten-point type:

"THIS ESTIMATE HAS BEEN PREPARED BASED ON THE USE OF AFTERMARKET CRASH PARTS SUPPLIED BY A SOURCE OTHER THAN THE MANUFACTURER OF YOUR MOTOR VEHICLE. THE AFTERMARKET CRASH PARTS USED IN THE PREPARATION OF THIS ESTIMATE ARE WARRANTED BY THE MANUFACTURER OR DISTRIBUTOR OF SUCH PARTS RATHER THAN THE MANUFACTURER OF YOUR VEHICLE."; and

(14) On and after July 1, 1992, no insurer, as defined in paragraph (4) of Code Section 33-1-2, shall issue, cause to be issued, renew, or provide coverage under any major medical insurance policy or plan containing a calendar year deductible or similar plan benefit period deductible which does not provide for a carry-over of the application of such deductible as provided in this paragraph. If all or any portion of an insured's or member's cash deductible for a calendar year or similar plan benefit period is applied against covered expenses incurred by the insured or member during the last three months of

the deductible accumulation period, the insured's or member's cash deductible for the next ensuing calendar year or similar benefit plan period shall be reduced by the amount so applied. The provisions of this paragraph shall apply to major medical insurance policies or plans which have a benefit plan period of less than 24 months, except policies or plans designed and issued to be compatible with a health savings account as set out in 26 U.S.C. Section 223 or a spending account as defined in Chapter 30B of this title. (Code 1933, § 56-713, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1971, p. 887, § 1; Code 1933, § 56-712, as redesignated by Ga. L. 1972, p. 1261, § 7; Ga. L. 1980, p. 1011, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 1983, p. 699, § 1; Ga. L. 1984, p. 22, § 33; Ga. L. 1985, p. 464, § 1; Ga. L. 1985, p. 1227, § 3; Ga. L. 1986, p. 695, § 3; Ga. L. 1989, p. 1396, § 1; Ga. L. 1992, p. 996, § 4; Ga. L. 1995, p. 1165, § 6; Ga. L. 1996, p. 6, § 33; Ga. L. 2000, p. 136, § 33; Ga. L. 2002, p. 441, § 3; Ga. L. 2002, p. 786, § 1; Ga. L. 2005, p. 481, § 1/HB 291.)

The 2002 amendments. The first 2002 amendment, effective July 1, 2002, added paragraph (12.1). The second 2002 amendment, effective May 13, 2002, substituted the present provisions of paragraph (12) for the former provisions which read: "No insurer shall cancel an entire line or class of business unless the insurer demonstrates to the satisfaction of the Commissioner that continuation of such business would violate the provisions of this title or would be hazardous to its policyholders or the public;". See Editor's notes for applicability.

The 2005 amendment, effective July 1, 2005, in paragraph (14), added the proviso at the end of the last sentence beginning with the language ", except policies or plans".

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2002, in paragraph (12), "canceling" was substituted for "cancelling" in division (A)(i) and subparagraph (B) and "Chapter 20A of this title" was substituted for "Chapter 20A of Title 33" in paragraph (12.1).

Editor's notes. — Ga. L. 2002, p. 441, § 1, not codified by the General Assembly, provides that: "This Act shall be known and may be cited as the 'Consumers' Health Insurance Protection Act.'"

Ga. L. 2002, p. 441, § 11, not codified by the General Assembly, provides that: "This Act shall apply only to health benefit plan contracts issued, delivered, issued for delivery, or renewed in this state on or after October 1, 2002; provided, however, that Section 8 of this Act shall apply to all claims relating to health care services provided on or after July 1, 2002. Any carrier, plan, network, panel, or agent thereof conducting a post-payment audit or imposing a retroactive denial on any claim initially submitted prior to July 1, 2002, shall, no later than June 30, 2003, provide written notice to the claimant of the intent to conduct such an audit or impose such a retroactive denial of any such claim or part thereof, including the specific reason for the audit or denial and shall complete the audit or retroactive denial and provide notice to the claimant of any payment or refund due prior to January 1, 2004." The reference to Section 8 of the Act apparently should be to Section 9 of the Act, which enacted Article 3 of Chapter 20A of this title.

Law reviews. — For note on the 2002 amendment of this section, see 19 Ga. St. U. L. Rev. 220 (2002).

JUDICIAL DECISIONS

Legislative intent. — Legislature's decision to restrict only mass cancellations and not mass renewals was not absurd or unjust, if the legislature had intended to restrict both, then it would have said so, as it did elsewhere in the unfair trade practices chapter. Ins. Dep't v. St. Paul Fire & Cas. Ins. Co., 253 Ga. App. 551, 559 S.E.2d 754 (2002).

Under O.C.G.A. § 33-6-5(12), "cancel" did not mean "nonrenew;" interpreting cancel in that manner would be contrary to the strict letter of the statute. By its plain terms, the statute limits the power of an insurer to cancel an entire line or class of business, thereby effectuating an immediate, widespread interruption of insurance coverage. Ins. Dep't v. St. Paul Fire & Cas. Ins. Co., 253 Ga. App. 551, 559 S.E.2d 754 (2002).

Cited in Nat'l Viatical, Inc. v. State, 258 Ga. App. 408, 574 S.E.2d 337 (2002).

ARTICLE 2

UNFAIR CLAIMS SETTLEMENT PRACTICES

33-6-34. Unfair claims settlement practices.

RESEARCH REFERENCES

ALR. — What constitutes bad faith on part of insurer rendering it liable for statutory penalty imposed for bad faith in failure to pay, or delay in paying, insured's claim — Particular conduct of insurer, 115 ALR5th 589.

What constitutes bad faith on part of insurer rendering it liable for statutory penalty imposed for bad faith in failure to pay, or delay in paying, insured's claim — Particular grounds for denial of claim: matters relating to policy, 116 ALR5th 247.

CHAPTER 7

KINDS OF INSURANCE; LIMITS OF RISKS; REINSURANCE

33-7-3. Casualty insurance.

RESEARCH REFERENCES

Am. Jur. Proof of Facts. — Formaldehyde Fumes Emitted by Building Materials, 3 POF3d 225.

Avoiding the "Business Pursuits" Exclusion — Insured's Activity as Not Business Pursuit, 15 POF3d 515.

Avoiding the "Business Pursuits" Exclusion — Insured's Activity as Ordinarily Incident to Nonbusiness Pursuits, 16 POF3d 355.

Am. Jur. Pleading and Practice Forms. — 14A Am. Jur. Pleading and Practice Forms, Insurance, § 34.

33-7-6. Property insurance; contract requirements; rules and regulations; exemptions.

(a) Property insurance is insurance on real or personal property of every kind and interest therein against loss or damage from any or all hazards or causes and against loss consequential upon such loss or damage other than noncontractual legal liability for any such loss or damage. Property insurance shall also include miscellaneous insurance as defined in paragraph (10) of Code Section 33-7-3, except as to any noncontractual liability coverage includable therein.

(b) Property insurance also includes:

(1) Any contract, agreement, or instrument whereby a person assumes the risk of and the expense or portion thereof for the mechanical breakdown or mechanical failure of a motor vehicle, or for the removal of dents, dings, or creases in a motor vehicle without affecting the existing paint finish using paintless dent repair techniques or the removal of small windshield chips and cracks without replacement of the entire windshield, and shall include those agreements commonly known as vehicle service agreements or extended warranty agreements, if made by a person other than the motor vehicle manufacturer in exchange for a separately stated charge or the cost of the contract or contracts is included on a nonidentifiable basis in the cost of a motor vehicle sold in conjunction therewith, except that this provision shall not apply to an agreement underwritten by an insurer licensed to transact insurance in this state, either directly or through a reinsurance contract or, without regard to the requirement that the insurance cannot be obtained from an insurer authorized to do business in this state as required by Code Section 33-5-21, to an agreement underwritten by a surplus lines insurer which has not been rejected by the Commissioner for such purpose;

(2) Any contract, agreement, or instrument whereby a person assumes the risk of and the expense or portion of such expense for the structural or mechanical breakdown, loss of, or damage to a one-family or two-family residential building structure or any part

thereof from any cause, including loss of or damage to or loss of use of the building structure or major components thereof which are attached to and become a part of said structure, if made by a person other than the constructing contractor or manufacturer of the building structure or part thereof in exchange for a separately stated charge or the cost of the contract or contracts is included on a nonidentifiable basis in the cost of such building structure sold in conjunction therewith, except that this provision shall not apply to an agreement underwritten by an insurer licensed to transact insurance in this state, either directly or through a reinsurance contract or underwritten by a surplus line insurer approved by the Commissioner nor shall this provision apply to an agreement: (A) the performance of which is guaranteed by a surety bond executed by an authorized corporate surety insurer in favor of and approved by the Commissioner in an amount of not less than $1.5 million; provided further that a surety bond of an additional $100,000.00 shall be required for every additional $500,000.00 in written premium above $2 million in written premium. Any company relying upon one or more bonds pursuant to this subsection shall keep such bonds or equivalent coverage in place until the expiration of the contract, agreement, or instrument contemplated in this paragraph; or (B) notwithstanding with a duration of 13 months or less covering damage to or loss of use of the major appliances located in an existing or resold home where the performance of any covered repair is guaranteed by a surety bond executed by a corporate surety insurer authorized to offer surety insurance in this state in favor of the Commissioner and in an amount which in the discretion of the Commissioner will provide adequate protection to all the residents of this state who are covered by such agreements, provided that such amount shall not be less than $100,000.00; or

(3) Any contract, agreement, or instrument, other than an agreement, contract, or instrument covered by paragraphs (1) and (2) of this subsection, whereby a person assumes the risk of and the expense or portion thereof for the cost of repair or replacement of a product if such contract, agreement, or instrument is made by a person other than the manufacturer in exchange for a separately stated charge or the cost of the contract or contracts is included on a nonidentifiable basis in the cost of the product sold in conjunction therewith, except that this provision shall not apply to:

(A) An agreement underwritten by an insurer licensed to transact insurance in this state, either directly or through a reinsurance contract;

(B) Any contract, agreement, or instrument relating to similar services furnished by any air carrier that provides interstate air transportation;

(C) Any tire replacement contract, agreement, or instrument;

(D) A contract, agreement, or instrument whereby a retailer in the business of selling consumer products or a wholly owned subsidiary of such retailer assumes the risk of and the expense or portion thereof for the cost of repair or replacement of consumer products where such contract, agreement, or instrument is guaranteed by a surety bond executed by a corporate surety insurer authorized to offer surety insurance in this state in favor of and approved by the Commissioner in an amount of not less than $100,000.00; or

(E) Any contract, agreement, or instrument whereby any person assumes the risk of and the expense or portion of such expense for the breakdown, service, repair, or replacement due to normal wear and tear or structural or inherent defect to the major appliances, utility systems, and roofing system of any one-family or two-family residential building structure in exchange for a separately stated consideration and does not otherwise provide direct or consequential coverage under a property contract defined in paragraph (1) or (2) of this subsection or the introductory language of this paragraph and such contract, agreement, or instrument is guaranteed by a surety bond executed by a corporate surety insurer authorized to offer surety insurance in this state in favor of and approved by the Commissioner in an amount of not less than $100,000.00.

(c)(1) Any contract, agreement, or instrument, as regulated under paragraphs (1), (2), and (3) of subsection (b) of this Code section, shall state clearly and conspicuously in the contract the name and address of the insurer or surety which has guaranteed or underwritten the contract, agreement, or instrument, either directly or through a reinsurance contract.

(2) In the event a regulated contract, agreement, or instrument is issued by a party other than an insurer so that the holder thereof, in the first instance, must make a claim or request for refund pursuant to paragraph (3) of this subsection against a party other than the insurer, the contract, agreement, or instrument shall provide that the holder shall be entitled to make a direct claim against the insurer upon the failure of the issuer to pay any claim or to refund the consideration paid by the holder for the contract, agreement, or instrument within 60 days after proof of loss has been filed with the issuer.

(3) The regulated contract, agreement, or instrument shall be noncancelable by the issuer except for fraud, material misrepresentation, or failure to pay the consideration due therefor. The cancellation shall be in writing and shall conform to the requirements of Code

Section 33-24-44. The holder may cancel at any time upon demand and surrender of the contract, agreement, or instrument whereupon the issuer shall refund the excess of the consideration paid for the contract, agreement, or instrument above the customary short rate for the expired term of the contract, agreement, or instrument.

(4) Any contract, agreement, or instrument exempt under subparagraph (b)(3)(D) or (b)(3)(E) of this Code section shall state clearly and conspicuously substantially the following: "This is not a contract of insurance."

(d) The Commissioner shall have the power and authority to promulgate rules and regulations regarding vehicle service agreements or extended warranty agreements as described in paragraph (1) of subsection (b) of this Code section. Such rules and regulations shall include filing requirements, disclosures for the benefit of the agreement holder, record keeping, and procedures for public complaints. Such rules and regulations shall also include the conditions under which surplus lines insurers may be rejected for the purpose of underwriting vehicle service agreements and extended warranty agreements.

(e)(1) As used in this subsection, the term "heavy equipment dealer" means a person, firm, or corporation which is primarily engaged in the business of selling, renting, leasing, and servicing heavy equipment, engines, power generation equipment, and parts and attachments to such heavy equipment which is primarily used for construction, industrial, maritime, mining, agriculture, or similar purposes and who is not required to be licensed.

(2) The provisions of this Code section shall not apply to heavy equipment dealers.

(f) Property insurance does not include those agreements commonly known as vehicle service agreements or extended warranty agreements which are issued, sold, or offered for sale by a retail installment seller, as defined in Code Section 10-1-31 in connection with the sale of a motor vehicle by such retail installment seller, provided that such retail installment seller:

(1) Maintains, or has a parent company maintain, a net worth or stockholders' equity of at least $50 million, provided the parent company guarantees the obligations of the retail installment seller arising from vehicle service agreements or extended warranty agreements underwritten pursuant to this subparagraph;

(2) Complies with the registration requirement prescribed by the Commissioner through regulation;

(3) Files with the Commissioner a true and correct copy of the vehicle service agreement or extended warranty agreement that has

a term of and is no longer than nine months in a form that is consistent with the terms prescribed by the Commissioner through regulation;

(4) Files a copy of its Form 10-K or Form 20-F disclosure statements, or if it does not file such statements with the United States Securities and Exchange Commission, a copy of its audited financial statements reported on a GAAP basis. If the retail installment seller's financial statements are consolidated with those of its parent company, then the retail installment seller may comply with this provision by filing the statements of its parent company. The statement shall be filed with the Commissioner 30 days prior to the retail installment seller's initial offering or delivering of a service agreement or extended warranty agreement, and thereafter, the statement shall be filed with the Commissioner annually; and

(5) Upon the request of the Commissioner, posts a security deposit or surety bond in an amount not to exceed $250,000.00 and in the manner prescribed by the Commissioner through regulation. (Code 1933, § 56-405, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1979, p. 804, § 1; Ga. L. 1980, p. 760, § 1; Ga. L. 1983, p. 864, § 1; Ga. L. 1984, p. 22, § 33; Ga. L. 1986, p. 1237, § 1; Ga. L. 1987, p. 3, § 33; Ga. L. 1988, p. 1467, §§ 1, 2; Ga. L. 1989, p. 680, § 1; Ga. L. 1992, p. 2389, §§ 1.1, 1.2; Ga. L. 1996, p. 912, § 3; Ga. L. 2000, p. 423, § 1; Ga. L. 2000, p. 859, § 1; Ga. L. 2002, p. 1037, § 1; Ga. L. 2005, p. 953, § 1/HB 428; Ga. L. 2006, p. 72, § 33/SB 465; Ga. L. 2008, p. 1021, § 1/SB 518; Ga. L. 2012, p. 1350, § 10/HB 1067.)

The 2002 amendment, effective May 14, 2002, in subparagraph (b)(3)(D), deleted "electrical or electronic" preceding "consumer products" in two places and inserted "or a wholly owned subsidiary of such retailer".

The 2005 amendment, effective July 1, 2005, in subsection (b), deleted "by reason of depreciation, deterioration, wear and tear, use, obsolescence, or breakage" following "part of said structure" in the first sentence of paragraph (b)(2), deleted "or" at the end of subparagraph (b)(3)(C), substituted "; or" for a period at the end of subparagraph (b)(3)(D), and added subparagraph (b)(3)(E); rewrote paragraph (c)(1) which read: "Any contract, agreement, or instrument, as defined in paragraphs (1), (2), and (3) of subsection (b) of this Code section, shall state clearly and conspicuously on the cover page the name and address of the insurer which has underwritten the contract, agreement, or instrument, either directly or through a reinsurance contract. Any contract, agreement, or instrument as defined in paragraphs (2) and (3) of subsection (b) of this Code section, the performance of which is guaranteed by a surety insurer, shall state clearly and conspicuously on the cover page the name, address, telephone number, and principal contact person of the surety insurer."; inserted "regulated" near the beginning of paragraphs (c)(2) and (c)(3); and added paragraph (c)(4).

The 2006 amendment, effective April 14, 2006, part of an Act to revise, modernize, and correct the Code, substituted "defined in paragraph (1) or (2) of this subsection or the introductory language of this paragraph and such contract" for "defined in paragraph (1) or (2) of this subsection (b) or the introductory language of

paragraph (3) of this subsection (b) and such contract" near the middle of subparagraph (b)(3)(E).

The 2008 amendment, effective July 1, 2008, inserted ", or for the removal of dents, dings, or creases in a motor vehicle without affecting the existing paint finish using paintless dent repair techniques or the removal of small windshield chips and cracks without replacement of the entire windshield," near the beginning of paragraph (b)(1).

The 2012 amendment, effective July 1, 2012, added subsection (f).

Law reviews. — For annual survey of construction law, see 57 Mercer L. Rev. 79 (2005).

33-7-8. Title insurance.

RESEARCH REFERENCES

Am. Jur. Proof of Facts. — Proof of Title Insurance Claims, 38 POF3d 389.

33-7-8.1. Closing protection letters; definitions; premiums regarding such letters; maintenance of adequate reserves; rules and regulations.

(a) As used in this Code section, the term:

(1) "Closing protection letter" means insurance that indemnifies a buyer, lender, or seller in transactions where title to real estate is being conveyed solely against losses not to exceed the amount of the settlement funds only because of the following acts of the person responsible for the disbursement of settlement funds:

(A) Acts of fraud, theft, dishonesty, or negligence in handling settlement funds or documents in connection with a closing, but only to the extent that the acts affect status or priority of title in the real estate insured by the title insurance; and

(B) Failure to comply with written closing instructions by a proposed insured when agreed to by the title agency or title agent relating to title insurance coverage, but only to the extent that the acts affect status or priority of title in real estate insured by the title insurance.

(2) "Settlement funds" means the total funds paid by the buyer, lender, or seller as consideration for the conveyance of real estate.

(b) A title insurer may issue closing protection letters only for real estate transactions where its title insurance policies are issued and where its issuing agent or agency is also responsible for the disbursement of settlement funds.

(c) The premium charged by the title insurer for closing protection letters shall be filed with and approved by the Commissioner in accordance with Chapter 9 of this title and shall not be subject to any

agreement requiring a division of the premium collected on behalf of the title insurer.

(d) Companies issuing closing protection letters shall maintain adequate reserves for those closing protection letters pursuant to Chapter 10 of this title.

(e) The Commissioner shall be authorized to promulgate rules and regulations necessary to implement this Code section, which shall include, but shall not be limited to, prescribing standard closing protection letter policy forms. (Code 1981, § 33-7-8.1, enacted by Ga. L. 2012, p. 1077, § 2/SB 331.)

Effective date. — This Code section became effective May 2, 2012.

33-7-11. Uninsured motorist coverage under motor vehicle liability policies.

(a)(1) No automobile liability policy or motor vehicle liability policy shall be issued or delivered in this state to the owner of such vehicle or shall be issued or delivered by any insurer licensed in this state upon any motor vehicle then principally garaged or principally used in this state unless it contains an endorsement or provisions undertaking to pay the insured damages for bodily injury, loss of consortium or death of an insured, or for injury to or destruction of property of an insured under the named insured's policy sustained from the owner or operator of an uninsured motor vehicle, within limits exclusive of interests and costs which at the option of the insured shall be:

(A) Not less than $25,000.00 because of bodily injury to or death of one person in any one accident, and, subject to such limit for one person, $50,000.00 because of bodily injury to or death of two or more persons in any one accident, and $25,000.00 because of injury to or destruction of property; or

(B) Equal to the limits of liability because of bodily injury to or death of one person in any one accident and of two or more persons in any one accident, and because of injury to or destruction of property of the insured which is contained in the insured's personal coverage in the automobile liability policy or motor vehicle liability policy issued by the insurer to the insured if those limits of liability exceed the limits of liability set forth in subparagraph (A) of this paragraph. In any event, the insured may affirmatively choose uninsured motorist limits in an amount less than the limits of liability.

(2) The coverages for bodily injury or death or for injury to or destruction of property of an insured person, as provided in para-

graph (1) of this subsection, may be subject to deductible amounts as follows:

(A) For bodily injury or death, deductibles of $250.00, $500.00, or $1,000.00, at the option of any named insured in the policy. Deductibles above $1,000.00 may be offered, subject to approval of the Commissioner;

(B) For injury to or destruction of property of the insured, deductibles of $250.00, $500.00, or $1,000.00, at the option of any named insured in the policy. Deductibles above $1,000.00 may be offered, subject to the approval of the Commissioner;

(C) Deductible amounts shown in subparagraphs (A) and (B) of this paragraph may not be reduced below $250.00;

(D) Deductible amounts shown in subparagraphs (A) and (B) of this paragraph shall be made available at a reduced premium; and

(E) Where an insurer has combined into one single limit the coverages required under paragraph (1) of this subsection, any deductible selected under subparagraphs (A) and (B) of this paragraph shall be combined, and the resultant total shall be construed to be a single aggregate deductible.

(3) The coverage required under paragraph (1) of this subsection shall not be applicable where any insured named in the policy shall reject the coverage in writing. The coverage required under paragraph (1) of this subsection excludes umbrella or excess liability policies unless affirmatively provided for in such policies or in a policy endorsement. The coverage need not be provided in or supplemental to a renewal policy where the named insured had rejected the coverage in connection with a policy previously issued to said insured by the same insurer. The amount of coverage need not be increased in a renewal policy from the amount shown on the declarations page for coverage existing prior to July 1, 2001. The amount of coverage need not be increased from the amounts shown on the declarations page on renewal once coverage is issued.

(4) The filing of a petition for relief in bankruptcy under a chapter of Title 11 of the United States Code by an uninsured motorist as defined in this Code section, or the appointment of a trustee in bankruptcy for an uninsured motorist as defined in this Code section, or the discharge in bankruptcy of an uninsured motorist as defined in this Code section shall not affect the legal liability of an uninsured motorist as the term "legal liability" is used in this Code section, and such filing of a petition for relief in voluntary or involuntary bankruptcy, the appointment of a trustee in bankruptcy, or the discharge in bankruptcy of such an uninsured motorist shall not be pleaded by

the insurance carrier providing uninsured motorist protection in bar of any claim of an insured person as defined in this Code section so as to defeat payment for damages sustained by any insured person by the insurance company providing uninsured motorist protection and coverage under the terms of this chapter as now or hereafter amended; but the insurance company or companies shall have the right to defend any such action in its own name or in the name of the uninsured motorist and shall make payment of any judgment up to the limits of the applicable uninsured motorist insurance protection afforded by its policy. In those cases, the uninsured motorist upon being discharged in bankruptcy may plead the discharge in bankruptcy against any subrogation claim of any uninsured motorist carrier making payment of a claim or judgment in favor of an uninsured person, and the uninsured motorist may plead said motorist's discharge in bankruptcy in bar of all amounts of an insured person's claim in excess of uninsured motorist protection available to the insured person.

(b)(1) As used in this Code section, the term:

(A) "Bodily injury" shall include death resulting from bodily injury.

(B) "Insured" means the named insured and, while resident of the same household, the spouse of any such named insured and relatives of either, while in a motor vehicle or otherwise; any person who uses, with the expressed or implied consent of the named insured, the motor vehicle to which the policy applies; a guest in such motor vehicle to which the policy applies; or the personal representatives of any of the above. For policies issued or renewed on or after July 1, 2006, the term "insured" shall also mean a foster child or ward residing in the household of the named insured pursuant to a court order, guardianship, or placement by the Department of Family and Children Services or other department or agency of the state, while in a motor vehicle or otherwise.

(C) "Property of the insured" as used in subsection (a) of this Code section means the insured motor vehicle and includes the personal property owned by the insured and contained in the insured motor vehicle.

(D) "Uninsured motor vehicle" means a motor vehicle, other than a motor vehicle owned by or furnished for the regular use of the named insured, the spouse of the named insured, and, while residents of the same household, the relative of either, as to which there is:

(i) No bodily injury liability insurance and property damage liability insurance;

(ii) Bodily injury liability insurance and property damage liability insurance and the insured has uninsured motorist coverage provided under the insured's motor vehicle insurance policy; the motor vehicle shall be considered uninsured, and the amount of available coverages shall be as follows:

(I) Such motor vehicle shall be considered uninsured to the full extent of the limits of the uninsured motorist coverage provided under the insured's motor vehicle insurance policies, and such coverages shall apply to the insured's losses in addition to the amounts payable under any available bodily injury liability and property damage liability insurance coverages. The insured's uninsured motorist coverage shall not be used to duplicate payments made under any available bodily injury liability insurance and property damage liability insurance coverages but instead shall be available as additional insurance coverage in excess of any available bodily injury liability insurance and property damage liability insurance coverages; provided, however, that the insured's combined recovery from the insured's uninsured motorist coverages and the available coverages under the bodily injury liability insurance and property damage liability insurance on such uninsured motor vehicle shall not exceed the sum of all economic and noneconomic losses sustained by the insured. For purposes of this subdivision, available coverages under the bodily injury liability insurance and property damage liability insurance coverages on such motor vehicle shall be the limits of coverage less any amounts by which the maximum amounts payable under such limits of coverage have, by reason of payment of other claims or otherwise, been reduced below the limits of coverage;

(II) Provided, however, that an insured may reject the coverage referenced in subdivision (I) of this division and select in writing coverage for the occurrence of sustaining losses from the owner or operator of an uninsured motor vehicle that considers such motor vehicle to be uninsured only for the amount of the difference between the available coverages under the bodily injury liability insurance and property damage liability insurance coverages on such motor vehicle and the limits of the uninsured motorist coverages provided under the insured's motor vehicle insurance policies; and, for purposes of this subdivision, available coverages under the bodily injury liability insurance and property damage liability insurance coverages on such motor vehicle shall be the limits of coverage less any amounts by which the maximum amounts payable under such limits of coverage have, by reason of payment of

other claims or otherwise, been reduced below the limits of coverage; and

(III) Neither coverage under subdivision (I) nor (II) of this division shall be applicable if the insured rejects such coverages as provided in paragraph (3) of subsection (a) of this Code section. For private passenger motor vehicle insurance policies in effect on January 1, 2009, insurers shall send to their insureds who have not rejected coverage pursuant to paragraph (3) of subsection (a) of this Code section a notice at least 45 days before the first renewal of such policies advising of the coverage options set forth in this division. Such notice shall not be required for any subsequent renewals for policies in effect on January 1, 2009, or for any renewals for policies issued after January 1, 2009. The coverage set forth in subdivision (I) of this division need not be provided in or supplemental to a renewal policy where the named insured has rejected the coverage set forth in subdivision (I) of this division and selected the coverage set forth in subdivision (II) of this division in connection with a policy previously issued to said insured by the same insurer;

(iii) Bodily injury liability insurance and property damage liability insurance in existence but the insurance company writing the insurance has legally denied coverage under its policy;

(iv) Bodily injury liability and property damage liability insurance in existence but the insurance company writing the insurance is unable, because of being insolvent, to make either full or partial payment with respect to the legal liability of its insured, provided that in the event that a partial payment is made by or on behalf of the insolvent insurer with respect to the legal liability of its insured, then the motor vehicle shall only be considered to be uninsured for the amount of the difference between the partial payment and the limits of the uninsured motorist coverage provided under the insured's motor vehicle insurance policy; or

(v) No bond or deposit of cash or securities in lieu of bodily injury and property damage liability insurance.

(2) A motor vehicle shall be deemed to be uninsured if the owner or operator of the motor vehicle is unknown. In those cases, recovery under the endorsement or provisions shall be subject to the conditions set forth in subsections (c) through (j) of this Code section, and, in order for the insured to recover under the endorsement where the owner or operator of any motor vehicle which causes bodily injury or

property damage to the insured is unknown, actual physical contact shall have occurred between the motor vehicle owned or operated by the unknown person and the person or property of the insured. Such physical contact shall not be required if the description by the claimant of how the occurrence occurred is corroborated by an eyewitness to the occurrence other than the claimant.

(c) If the owner or operator of any motor vehicle which causes bodily injury or property damage to the insured is unknown, the insured, or someone on his behalf, or in the event of a death claim someone on behalf of the party having the claim, in order for the insured to recover under the endorsement, shall report the accident as required by Code Section 40-6-273.

(d) In cases where the owner or operator of any vehicle causing injury or damages is known, and either or both are named as defendants in any action for such injury or damages, and a reasonable belief exists that the vehicle is an uninsured motor vehicle under subparagraph (b)(1)(D) of this Code section, a copy of the action and all pleadings thereto shall be served as prescribed by law upon the insurance company issuing the policy as though the insurance company were actually named as a party defendant. If facts arise after an action has been commenced which create a reasonable belief that a vehicle is an uninsured motor vehicle under subparagraph (b)(1)(D) of this Code section and no such reasonable belief existed prior to the commencement of the action against the defendant, and the complaint was timely served on the defendant, the insurance company issuing the policy shall be served within either the remainder of the time allowed for valid service on the defendant or 90 days after the date on which the party seeking relief discovered, or in the exercise of due diligence should have discovered, that the vehicle was uninsured or underinsured, whichever period is greater. The uninsured motorist carrier may conduct discovery as a matter of right for a period of not less than 120 days after service prior to any hearing on the merits of the action. If either the owner or operator of any vehicle causing injury or damages is unknown, an action may be instituted against the unknown defendant as "John Doe," and a copy of the action and all pleadings thereto shall be served as prescribed by law upon the insurance company issuing the policy as though the insurance company were actually named as a party defendant; and the insurance company shall have the right to file pleadings and take other action allowable by law in the name of "John Doe" or itself. In any case arising under this Code section where service upon an insurance company is prescribed, the clerk of the court in which the action is brought shall have such service accomplished by issuing a duplicate original copy for the sheriff or marshal to place his or her return of service in the same form and manner as prescribed by law for a party defendant. The return of service upon the insurance company

shall in no case appear upon the original pleadings in such case. In the case of a known owner or operator of such vehicle, either or both of whom are named as a defendant in such action, the insurance company issuing the policy shall have the right to file pleadings and take other action allowable by law in the name of either the known owner or operator or both or itself.

(1) In cases where the owner or operator of a vehicle causing injury or damages is unknown and an action is instituted against the unknown defendant as "John Doe," the residence of such "John Doe" defendant shall be presumed to be in the county in which the accident causing injury or damages occurred, or in the county of residence of the plaintiff, at the election of the plaintiff in the action.

(2) A motor vehicle shall not be deemed to be an uninsured motor vehicle within the meaning of this Code section when the owner or operator of such motor vehicle has deposited security, pursuant to Code Section 40-9-32, in the amounts specified in subparagraph (a)(1)(A) of this Code section.

(e) In cases where the owner or operator of any vehicle causing injury or damage is known and either or both are named as defendants in any action for such injury or damages but the person resides out of the state, has departed from the state, cannot after due diligence be found within the state, or conceals himself to avoid the service of summons, and this fact shall appear by affidavit to the satisfaction of the judge of the court, and it shall appear either by affidavit or by a verified complaint on file that a claim exists against the owner or driver in respect to whom service is to be made and that he is a necessary or proper party to the action, the judge may grant an order that the service be made on the owner or driver by the publication of summons. A copy of any action filed and all pleadings thereto shall be served as prescribed by law upon the insurance company issuing the policy as though the insurance company issuing the policy were actually named as a party defendant. Subsection (d) of this Code section shall govern the rights of the insurance company, the duties of the clerk of court concerning duplicate original copies of the pleadings, and the return of service. Following service on the owner or driver by the publication of the summons as provided in this subsection and service as prescribed by law upon the insurance company issuing the policy, the plaintiff shall have a continuing duty to exercise diligence in attempting to locate the owner or driver against whom the claim exists, but such obligation of diligence shall not extend beyond a period of 12 months following service upon the owner or driver by publication of the summons. However, regardless of such time limitations, should the plaintiff learn of the location of the owner or driver against whom the claim exists, the plaintiff shall exercise due diligence to effect service of process upon that owner or driver within a reasonable time period after receiving such information.

(f) An insurer paying a claim under the endorsement or provisions required by subsection (a) of this Code section shall be subrogated to the rights of the insured to whom the claim was paid against the person causing such injury, death, or damage to the extent that payment was made, including the proceeds recoverable from the assets of the insolvent insurer, provided that the bringing of an action against the unknown owner or operator as "John Doe" or the conclusion of such an action shall not constitute a bar to the insured, if the identity of the owner or operator who caused the injury or damages complained of becomes known, bringing an action against the owner or operator theretofore proceeded against as "John Doe"; provided, further, that any recovery against such owner or operator shall be paid to the insurance company to the extent that the insurance company paid the named insured in the action brought against the owner or operator as "John Doe," except that the insurance company shall pay its proportionate part of any reasonable costs and expense incurred in connection therewith, including reasonable attorney's fees. Nothing in an endorsement or provisions made under this Code section nor any other provision of law shall operate to prevent the joining in an action against "John Doe" or the owner or operator of the motor vehicle causing such injury as a party defendant, and joinder is specifically authorized.

(g) No endorsement or provisions shall contain a provision requiring arbitration of any claim arising under any endorsement or provisions, nor may anything be required of the insured, subject to the other provisions of the policy or contract, except the establishment of legal liability; nor shall the insured be restricted or prevented, in any manner, from employing legal counsel or instituting legal proceedings.

(h) Before a motor vehicle shall be deemed to be uninsured because of the insolvency of an insurance company under division (b)(1)(D)(iv) of this Code section, an insurer under the uninsured motorists endorsement provisions of subsection (a) of this Code section must be given notice within a reasonable time by its insured of the pendency of any legal proceeding against such insurance company of which he may have knowledge, and before the insured enters into any negotiation or arrangement with the insurance company, and before the insurer is prejudiced by any action or nonaction of the insured with respect to the determinations of the insolvency of the insurance company.

(i) In addition to any offsets or reductions contained in the provisions of division (b)(1)(D)(ii) of this Code section, an endorsement or the provisions of the policy providing the coverage required by this Code section may contain provisions which exclude any liability of the insurer for injury to or destruction of property of the insured for which such insured has been compensated by other property or physical damage insurance and may contain provisions which exclude any

liability of the insurer for personal or bodily injury or death for which the insured has been compensated pursuant to "medical payments coverage," as such term is defined in paragraph (1) of Code Section 33-34-2, or compensated pursuant to workers' compensation laws.

(j) If the insurer shall refuse to pay any insured any loss covered by this Code section within 60 days after a demand has been made by the insured and a finding has been made that such refusal was made in bad faith, the insurer shall be liable to the insured in addition to any recovery under this Code section for not more than 25 percent of the recovery and all reasonable attorney's fees for the prosecution of the case under this Code section. The question of bad faith, the amount of the penalty, if any, and the reasonable attorney's fees, if any, shall be determined in a separate action filed by the insured against the insurer after a judgment has been rendered against the uninsured motorist in the original tort action. The attorney's fees shall be fixed on the basis of competent expert evidence as to the reasonable value of the services, based on the time spent and legal and factual issues involved, in accordance with prevailing fees in the locality where the action is pending. The trial court shall have the discretion, if it finds such jury verdict fixing attorney's fees to be greatly excessive or inadequate, to review and amend such portion of the verdict fixing attorney's fees without the necessity of disapproving the entire verdict. The limitations contained in this subsection in reference to the amount of attorney's fees are not controlling as to the fees which may be agreed upon by the plaintiff and his attorney for the services of the attorney in the action against the insurer. (Code 1933, § 56-407A, enacted by Ga. L. 1963, p. 588, § 1; Ga. L. 1964, p. 306, § 1; Ga. L. 1967, p. 463, § 1; Ga. L. 1968, p. 1089, §§ 1, 2; Ga. L. 1968, p. 1415, § 1; Ga. L. 1971, p. 926, §§ 1, 2; Ga. L. 1972, p. 882, § 1; Ga. L. 1973, p. 487, § 1; Ga. L. 1975, p. 1221, § 1; Ga. L. 1976, p. 1195, § 1; Ga. L. 1978, p. 1895, § 1; Ga. L. 1980, p. 1428, § 1; Ga. L. 1983, p. 938, § 1; Ga. L. 1984, p. 839, §§ 1-3; Ga. L. 1985, p. 149, § 33; Ga. L. 1986, p. 394, § 1; Ga. L. 1987, p. 3, § 33; Ga. L. 1991, p. 1608, § 1.4; Ga. L. 1994, p. 97, § 33; Ga. L. 1998, p. 1064, § 3; Ga. L. 2000, p. 1516, § 1; Ga. L. 2001, p. 1228, §§ 1, 2; Ga. L. 2006, p. 72, § 33/SB 465; Ga. L. 2006, p. 815, §§ 1-3/SB 531; Ga. L. 2008, p. 1192, §§ 1, 2/SB 276.)

The 2001 amendment, effective July 1, 2001, in paragraph (a)(1), added "or" at the end of subparagraph (a)(1)(A) and, in subparagraph (a)(1)(B), substituted "Equal to" for "Not greater than" at the beginning, added "if those limits of liability exceed the limits of liability set forth in subparagraph (a)(1)(A) of this Code section", and added the last sentence; and, in paragraph (a)(3), deleted "minimum" preceding "coverage" in the first sentence, deleted the former second sentence which read: "However, the insurer shall not be required to issue any coverage for any amount greater than the minimum coverage unless the insured shall request in writing such higher limits.", and added the last two sentences.

The 2006 amendments. — The first 2006 amendment, effective April 14, 2006,

part of an Act to revise, modernize, and correct the Code, deleted "of this Code section" following "subparagraph (A) of this paragraph" at the end of the first sentence of subparagraph (a)(1)(B). The second 2006 amendment, effective July 1, 2006, substituted "for bodily injury, loss of consortium or death of an insured or for injury to or destruction of property of an insured under the named insured's policy sustained" for "all sums which said insured shall be legally entitled to recover as" near the end of paragraph (a)(1), deleted "of this Code section" at the end of the first sentence of subparagraph (a)(1)(B), and substituted "an insured person" for "the insured" in paragraph (a)(2); added the second sentence in subparagraph (b)(1)(B); and added the fourth and fifth sentences in subsection (e).

The 2008 amendment, effective January 1, 2009, in paragraph (a)(1), inserted a comma following "death of an insured"; in subparagraph (a)(2)(E), inserted a comma following "combined" near the end; in paragraph (a)(3), added the second sentence; in paragraph (a)(4), in the last sentence, inserted a comma after "In those cases"; rewrote division (b)(1)(D)(ii); in paragraph (b)(2), in the second sentence, added a comma after "Code section", and substituted "shall have" for "must have" near the middle; and, in subsection (i), substituted "In addition to any offsets or reductions contained in the provisions of division (b)(1)(D)(ii) of this Code section, an endorsement or the provisions" for "The endorsement or provisions" at the beginning, near the middle, inserted "to", substituted "such insured has been" for "he has been", and added the language at the end beginning with "and may contain provisions". See the editor's note for applicability.

Cross references. — Insurance requirements for operation of motor vehicles generally, § 40-6-10.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2001, "subparagraph (A) of this paragraph" was substituted for "subparagraph (a)(1)(A)" in subparagraph (a)(1)(B) and "July 1, 2001" was substituted for "the effective date of this paragraph" in paragraph (a)(3).

Editor's notes. — Ga. L. 2001, p. 1228, § 3, not codified by the General Assembly, provides that: "Sections 1 and 2 of this Act shall only apply to policies issued or renewed on or after January 1, 2002."

Ga. L. 2006, p. 815, § 4, not codified by the General Assembly, provides that: "Section 1 of this Act shall apply to all policies issued, delivered, or issued for delivery in this state on and after such date."

Ga. L. 2008, p. 1192, § 5, not codified by the General Assembly, provides that the amendment to this Code section shall apply to all policies issued, delivered, issued for delivery, or renewed in this state on and after January 1, 2009.

Law reviews. — For annual survey article on evidence law, see 52 Mercer L. Rev. 303 (2000). For annual survey article discussing trial practice and procedure, see 52 Mercer L. Rev. 447 (2000). For article, "Insurance," see 53 Mercer L. Rev. 281 (2001). For survey article on insurance law for the period from June 1, 2002 through May 31, 2003, see 55 Mercer L. Rev. 277 (2003). For survey article on trial practice and procedure for the period from June 1, 2002 to May 31, 2003, see 55 Mercer L. Rev. 439 (2003). For article, "Bad Faith in Insurance Claim Handling in Georgia: An Overview and Update," see 9 Ga. St. B.J. 10 (2003). For annual survey of insurance law, see 56 Mercer L. Rev. 253 (2004). For annual survey of insurance law, see 57 Mercer L. Rev. 221 (2005). For annual survey of trial practice and procedure, see 57 Mercer L. Rev. 381 (2005). For annual survey of insurance law, see 58 Mercer L. Rev. 181 (2006). For survey article on evidence law, see 59 Mercer L. Rev. 157 (2007). For survey article on insurance law, see 59 Mercer L. Rev. 195 (2007). For survey article on trial practice and procedure, see 59 Mercer L. Rev. 423 (2007). For survey article on insurance law, see 60 Mercer L. Rev. 191 (2008). For survey article on trial practice and procedure, see 60 Mercer L. Rev. 397 (2008). For annual survey on insurance, see 61 Mercer L. Rev. 179 (2009). For annual survey of law on insurance, see 62 Mercer L. Rev. 139 (2010). For annual survey of law on trial practice and procedure, see 62 Mercer L. Rev. 339 (2010).

For note on the 2001 amendment to O.C.G.A. § 33-7-11, see 18 Ga. St. U. L. Rev. 177 (2001).

JUDICIAL DECISIONS

Analysis

General Consideration

Legislative intent.

Because Georgia public policy prohibited an exclusion within an insurer's uninsured coverage for the use of any motor vehicle by an insured to carry persons or property for a fee, as such denied the statutorily mandated coverage to an otherwise qualified insured, and the requirements under O.C.G.A. § 33-7-11 were plain and not illogical, summary judgment in favor of the insurer on this issue was reversed. Wagner v. Nationwide Mut. Fire Ins. Co., 288 Ga. App. 132, 653 S.E.2d 526 (2007).

Construction with Captive Insurance Company Act. — To the extent uninsured motorist provisions are inconsistent with the Georgia Captive Insurance Company Act, O.C.G.A. § 33-4-1 et seq., those provisions would not apply to captive insurance companies as set forth in the Act, O.C.G.A. § 33-41-24, because other controlling statutory mandates and strictures may result in the insurer providing some uninsured motorist coverage without being subject to other provisions of the uninsured motorist statute; the captive insurer is not required to insure a risk that the insurer is prohibited from insuring under the Act. VFH Captive Ins. Co. v. Pleitez, 307 Ga. App. 240, 704 S.E.2d 476 (2010).

Coverage agreement with Georgia Interlocal Risk Management Agency excluded uninsured and underinsured motorist protection. — Court of appeals correctly determined that no statute required that a city's agreement with the Georgia Interlocal Risk Management Agency (GIRMA) had to meet the uninsured and underinsured motorist coverage requirements that an insurance policy issued by an insurer had to meet pursuant to O.C.G.A. § 33-7-11 because the General Assembly explicitly declared that GIRMA was not an insurer; the city's agreement with GIRMA was limited to its express terms and did not include underinsured motorist protection. Godfrey v. Ga. Interlocal Risk Mgmt. Agency, 290 Ga. 211, 719 S.E.2d 412 (2011).

Applicability. — O.C.G.A. § 33-7-11 provides the basis for stacking by requiring insurance companies to have a provision in their contracts to pay the insured all sums which said insured shall be legally entitled to recover as damages from the owner or operator of an uninsured motor vehicle. Furthermore, the section creates two categories of insured persons; the first consists of the named insured and, while resident of the same household, the spouse of any such named insured and relatives of either, while in a motor vehicle or otherwise; and the second category of insured persons consists of any person who uses, with the expressed or implied consent of the named insured, the motor vehicle to which the policy applies, i.e. a guest in such motor vehicle to which the policy applies. Unlike the first provision, this second one contains language that conditions status as an insured on the involvement of the motor vehicle to which the policy applies and this class of insured persons is covered only when the insured automobile is involved. Beard v. Nunes, 269 Ga. App. 214, 603 S.E.2d 735 (Aug. 23, 2004).

Language of O.C.G.A. § 33-7-11(a)(1) is plain and is not illogical; the statute clearly states that an insurer is to pay all sums that the insured is legally entitled to recover as damages from the owner or operator of an uninsured motor vehicle, and "all" means every single one. Gordon v. Atlanta Cas. Co., 279 Ga. 148, 611 S.E.2d 24 (2005).

While service by publication could be used pursuant to O.C.G.A. § 33-7-11 for purposes of complying with the condition precedent for pursuing one's uninsured motorist insurance carrier, it was insufficient to confer personal jurisdiction; O.C.G.A. § 9-2-61(a) applied only to actions that were valid before dismissal, which required personal service on the defendant, and where there was only service by publication, and no personal service, in the initial suit, O.C.G.A. § 9-2-61(a) was inapplicable to a later suit based on same accident, and that later suit was time-barred. Costello v. Bothers, 278 Ga. App. 750, 629 S.E.2d 599 (2006).

Enforcing the intra-family exclusion did not conflict with Georgia's compulsory insurance law because a decedent was insured, and the decedent's spouse's estate was compensated under a general liability policy for the full amount required under such law; moreover, an intra-family exclusion under the decedent's insurance policy did not violate public policy because it did not prevent recovery of the compulsory minimum insurance amount. Hoque v. Empire Fire & Marine Ins. Co., 281 Ga. App. 810, 637 S.E.2d 465 (2006).

Because a personal injury plaintiff failed to file said action against an uninsured/underinsured motorist insurer within the applicable statutory period, and the action was not subject to renewal, as the magistrate court's determined that service was made by an unauthorized person, thus rendering the original action void, the insurer was entitled to dismissal. Lewis v. Waller, 282 Ga. App. 8, 637 S.E.2d 505 (2006).

When an insured settled with a driver who injured the insured, the insured could not also recover uninsured motorist benefits from the insured's insurer because an amendment to O.C.G.A. § 33-7-11 which would allow such recovery did not apply retroactively to the relevant accident, as the amendment: (1) created new rights on the part of an insured, by giving an insured the ability to elect to have excess uninsured motorist coverage, a reduction in that coverage, or no uninsured motorist coverage at all; and (2) affected an insurer's rights by requiring an insurer to provide excess coverage unless an insured specifically rejected such coverage, so the amendment was substantive in nature. McConville v. Cotton States Mut. Ins. Co., No. A11A1644, 2012 Ga. App. LEXIS 302 (Mar. 20, 2012).

Nothing in the 2001 amendment required an insurer to notify its policyholders who had chosen the statutory minimum amounts of uninsured motorist (UM) coverage that optional UM coverage was required to be equal to the liability limits of the underlying policy; an injured person's UM coverage was the minimum elected before the 2001 amendment to O.C.G.A. § 33-7-11, despite the fact that the liability limits of the policy at issue were higher than the elected UM coverage. Tice v. Am. Employers' Ins. Co., 275 Ga. App. 125, 619 S.E.2d 797 (2005).

In an action concerning the limits of uninsured motorist (UM) coverage available under a claimant's policy, which was held with the claimant's husband who was the named insured thereunder, their insurer was properly granted summary judgment on the issue, as the 2001 amendment to O.C.G.A. § 33-7-11 had no effect on the limits of UM coverage under the policy covering the claimant's vehicle, and as such, the insurer was not required to notify the claimant of the change in the law or to secure a separate UM election at the time this vehicle was added to the original insurance policy. Soufi v. Haygood, 282 Ga. App. 593, 639 S.E.2d 395 (2006).

Captive insurance company act does not prohibit uninsured motorist coverage. — There is nothing in the Georgia Captive Insurance Company Act, O.C.G.A. § 33-41-1 et seq., that explicitly prohibits a captive insurer from offering uninsured motorist coverage, and thus the Act does not directly conflict with the requirement contained in O.C.G.A. § 33-7-11 that motor vehicle liability policies must include uninsured motorist coverage unless the insured has rejected that coverage in writing, but the mandate contained in the Act, O.C.G.A. § 33-41-3(b) is explicit; uninsured motorist coverage, unless rejected in writing, is such a minimum requirement under Georgia law, and the General Assembly is presumed to have acted with full knowledge of that require-

ment in enacting the provisions of the Act. VFH Captive Ins. Co. v. Pleitez, 307 Ga. App. 240, 704 S.E.2d 476 (2010).

No setoff for personal injury benefits. — The plain meaning of O.C.G.A. § 33-7-11(i) is that an uninsured motorist carrier can set off benefits which its insured may have received to compensate for property loss; this being so, the Supreme Court of Georgia must conclude that the legislature did not intend to authorize an insurer to set off benefits received for personal injury. That is because when a statute expressly mentions one of many things, the omitted things must be regarded as having been deliberately excluded. Dees v. Logan, 282 Ga. 815, 653 S.E.2d 735 (2007).

An uninsured motorist carrier was not entitled to set off sums the insureds had received from workers' compensation, Social Security disability, and a settlement with a liability insurer. O.C.G.A. § 33-7-11(i) did not state that an insurer could set off benefits received for personal injuries; inasmuch as a policy provision such as the one here permitted a setoff for personal injury benefits, it was in conflict with the Uninsured Motorist Act and was thus unenforceable. Dees v. Logan, 282 Ga. 815, 653 S.E.2d 735 (2007).

Uninsured motorist carrier's motion to reduce a jury verdict to a motorist, who was injured in a motor vehicle accident, by the amount of pre-trial medical expense payments the insurer made to the motorist under an insurance policy was properly denied as the carrier was not permitted to set off benefits received for personal injury from collateral sources under O.C.G.A. § 33-7-11(i). State Farm Mut. Auto. Ins. Co. v. Hall, 309 Ga. App. 271, 709 S.E.2d 867 (2011).

Setoff for amount paid directly to hospital. — Under O.C.G.A. § 33-7-11(b)(1)(D)(ii), a uninsured motorist (UM) carrier was entitled to set off a payment that the tortfeasor's liability carrier made directly to a hospital that had a hospital lien. The insured's election to divert part of the liability payment to satisfy the insured's hospital bill did not reduce the available liability coverage or increase the insured's UM coverage; the cases relied upon by the insured were not controlling, as payment under the hospital lien statute, O.C.G.A. § 44-14-470, was not mandatory. Adams v. State Farm Mut. Auto. Ins. Co., No. A08A2315, 2009 Ga. App. LEXIS 151 (Feb. 17, 2009).

UIM insurer entitled to credit for hospital lien paid by tortfeasor's insurer. — Under O.C.G.A. §§ 33-7-11(b)(1)(D)(ii) (underinsured motorist coverage) and 44-14-470(b) (hospital liens), a tortfeasor's insurer's payment of a hospital lien represented partial satisfaction of an injured insured's claim; the injured insured's UIM carrier was entitled to a credit for the payment of the lien against its coverage. State Farm Mut. Auto. Ins. Co. v. Adams, 288 Ga. 315, 702 S.E.2d 898 (2010).

Federal preemption. — Trial court erroneously granted summary judgment to an UM insurer, where the injured claimant, who was also a federal employee, fell under the purview of federal compensation law; thus, under these federal provisions, the medical benefits insurer and the workers' compensation insurer had subrogation liens and were able to enforce them upon the injured party's receipt of a settlement from the liable third party, regardless of Georgia's requirement that such action be preceded by a determination that the injured person had been fully compensated. Thurman v. State Farm Mut. Auto. Ins. Co., 278 Ga. 162, 598 S.E.2d 448 (2004).

No need for increase on renewal. — Uninsured motorist coverage did not need to be increased in a renewal policy from the amount shown for coverage existing before July 1, 2001; under O.C.G.A. § 33-7-11(a)(3), an insurer was under no obligation to increase uninsured motorist limits to the amount of the policy's bodily injury liability coverage when the policy, which was initially issued before July 1, 2001, was later renewed. McKinnon v. Progressive Bayside Ins. Co., 278 Ga. App. 429, 629 S.E.2d 100 (2006).

Renewal status limited amount of liability. — In a suit wherein a driver sought uninsured motorist coverage from the insurer of an employer, the trial court erred by granting summary judgment to the driver and holding that the driver was entitled to uninsured motorist benefits in

the amount of $1,000,000, the liability limits, as the policy at issue was a renewal policy under O.C.G.A. § 33-7-11(a)(1) and, therefore, the amount of coverage was $75,000. Zurich Am. Ins. Co. v. Beasley, 293 Ga. App. 8, 666 S.E.2d 83 (2008).

Because an insurance policy was issued by the same insurer to supersede an existing policy and to extend the term of the existing policy beyond its policy period conditioned upon payment of a continuation premium, the fact that it bore a slightly different number and that there were changes in the premium amounts and the vehicles insured did not mean that it was a new policy rather than a renewal under O.C.G.A. § 33-24-45(b)(2). Thus, uninsured motorist coverage was not the $1,000,000 liability limit under O.C.G.A. § 33-7-11(a), but the $25,000 per person limit that the insureds had previously selected. Roberson v. Leone, No. A11A1972, 2012 Ga. App. LEXIS 324 (Mar. 22, 2012).

Renewal of earlier policy continued coverage. — Trial court erred in denying a commercial vehicle liability insurer's motions for directed verdict and judgment notwithstanding the verdict because the insurer was entitled to judgment, as a matter of law, that an employer's 2007 commercial vehicle insurance policy provided uninsured motorist (UM) coverage of $ 50,000 per person, as indicated on the policy's declarations page; by the policy's terms, the 2006 policy, which was unambiguous, carried forward the same obligation to insure that the insurer had under the prior policy, and because, as a matter of law, the 2006 policy was a renewal of an earlier policy, under O.C.G.A. § 33-7-11(a)(3), the employer was not required to make a new affirmative election of UM coverage to retain the $ 50,000 in coverage provided under the earlier policy. Infinity Gen. Ins. Co. v. Litton, 308 Ga. App. 497, 707 S.E.2d 885 (2011), cert. denied, No. S11C1110, 2011 Ga. LEXIS 580 (Ga. 2011).

Conflicting provisions void.

Summary judgment for an insurer was reversed as: (1) there was no judicial exemption in O.C.G.A. § 33-7-11 for umbrella or excess policies, absent express direction from the Georgia legislature, and umbrella and excess policies that provided motor vehicle or automobile liability coverage were subject to O.C.G.A. § 33-7-11; (2) the insurer's claim that uninsured motorist (UM) coverage was not required because the policy was a renewal policy was rejected since O.C.G.A. § 33-7-11(a)(3) provided that an insurer was not required to increase UM coverage in renewal policies; and (3) the provisions in the insureds' umbrella policy that excluded UM coverage conflicted with O.C.G.A. § 33-7-11 and were void. Abrohams v. Atl. Mut. Ins. Agency, 282 Ga. App. 176, 638 S.E.2d 330 (2006), cert. denied, 2007 Ga. LEXIS 155 (Ga. 2007).

Inasmuch as an uninsured policy provision permits a setoff for personal injury benefits, it is in conflict with the plain mandate of the Uninsured Motorist Act. It follows that such a policy provision is void and unenforceable. Dees v. Logan, 282 Ga. 815, 653 S.E.2d 735 (2007).

Insurer entitled to uninsured motorist coverage. — Trial court did not err by finding that an insured was entitled to uninsured motorist coverage under the insured's policy with a captive insurer because the policy the insurer issued to the insured did not expressly include uninsured motorist coverage, and the insurer did not obtain a written rejection of that coverage from the insured; the accident involved the named insured, and the insured was engaged in responsibilities arising out of the insured's job as a taxi cab driver, not personal or family responsibilities, at the time the insured was injured. VFH Captive Ins. Co. v. Pleitez, 307 Ga. App. 240, 704 S.E.2d 476 (2010).

There are no exceptions or qualifications, etc.

There is no judicial exemption from O.C.G.A. § 33-7-11's requirement for uninsured motorist coverage for umbrella or excess policies, absent express direction from the Georgia legislature; umbrella and excess policies that provide motor vehicle or automobile liability coverage are subject to O.C.G.A. § 33-7-11. Abrohams v. Atl. Mut. Ins. Agency, 282 Ga. App. 176, 638 S.E.2d 330 (2006), cert. denied, 2007 Ga. LEXIS 155 (Ga. 2007).

Umbrella insurance policy subject to stacking. — In a dispute involving priority of coverage between two unin-

sured motorist carriers and three policies, the trial court erred by placing an umbrella policy last in priority of the three since the decedent involved in a motor vehicle incident was more closely identified with the umbrella policy. The trial court's decision placing the umbrella policy third in priority was misplaced as such policies were to be stacked as other policies to provide uninsured motorist coverage under O.C.G.A. § 33-7-11(b)(1)(D)(ii). Progressive Classic Ins. Co. v. Nationwide Mut. Fire Ins. Co., 294 Ga. App. 787, 670 S.E.2d 497 (2008), cert. denied, No. S09C0494, 2009 Ga. LEXIS 202 (Ga. 2009).

Sublimits permissible. — Statutory minimum for underinsured motorist (UM) coverage is provided in O.C.G.A. § 33-7-11(a)(1)(A); under O.C.G.A. § 33-34-3.1(b), as long as the mandatory UM minimum is met and optional UM coverage is offered pursuant to statutory requirements, a combination of sublimits and interests restricted to named insureds and resident relatives contravenes neither the law nor public policy. Crouch v. Federated Mut. Ins. Co., 257 Ga. App. 604, 571 S.E.2d 574 (2002).

No uninsured motorist coverage. — Where an insured was a passenger in a vehicle that the insured owned and had insured at the time of a single-car accident, the insured was not entitled to uninsured motorist protection under the terms of an insurance policy or O.C.G.A. § 33-7-11(b)(1)(D); accordingly, the trial court did not err in so finding and properly granted summary judgment. Smith v. Nationwide Mut. Ins. Co., 258 Ga. App. 570, 574 S.E.2d 627 (2002).

Clarification of procedure for addressing stacking. — Statement in Dairyland Ins. Co. v. State Farm Automobile Ins. Co., 289 Ga. App. 216 (2008), that courts may also look to other insurance clauses in the contracts for resolution of the priority issue contradicts other cases and does not address the issue of stacking uninsured motorist policies, but rather considers which of several policies provide primary insurance and which insurer had the duty to defend. Accordingly, the Court of Appeals of Georgia disapproves of the language in Dairyland to the extent that the language conflicts with the court's decision in Nationwide Mutual Fire Insurance Company v. Progressive Classic Insurance Company, 278 Ga. App. 73 (2006). Progressive Classic Ins. Co. v. Nationwide Mut. Fire Ins. Co., 294 Ga. App. 787, 670 S.E.2d 497 (2008), cert. denied, No. S09C0494, 2009 Ga. LEXIS 202 (Ga. 2009).

Other policy not providing uninsured motorist coverage will be disregarded.

Several Georgia cases have held that "anti-stacking" or "other insurance" clauses in automobile insurance contracts are not enforceable, but those cases are limited to uninsured motorist cases where a specific statute, O.C.G.A. § 33-7-11(a)(1), has been interpreted to render such clauses unenforceable in the context of an uninsured motorist case. Plantation Pipeline Co. v. Cont'l Cas. Co., No. 1:03-CV-2811-WBH, 2008 U.S. Dist. LEXIS 80680 (N.D. Ga. July 8, 2008).

Insured could not show entitlement to recovery. — Trial court properly granted an insurer's summary judgment motion in an insured's suit for uninsured motorist benefits as the insured's suit against a sheriff's deputy in the deputy's official capacity was barred by the statute of limitations, and the insured could not establish that the insured was legally entitled to recover from the deputy, as required by O.C.G.A. § 33-7-11(a)(1). Soley v. State Farm Mut. Auto. Ins. Co., 267 Ga. App. 606, 600 S.E.2d 707 (2004).

Only requirement is entitlement to recover damages. — All that O.C.G.A. § 33-7-11(a)(1) requires is that an insured person be legally entitled to recover damages. Gordon v. Atlanta Cas. Co., 279 Ga. 148, 611 S.E.2d 24 (2005).

Insurer obligated even though injured person not covered under policy. — Insured was entitled to recover from the insurer under O.C.G.A. § 33-7-11(a)(1) for a son's death, even though the son was not a "covered person" under the policy, because the insured was entitled to recover damages from an owner or an operator of an uninsured motor vehicle. Gordon v. Atlanta Cas. Co., 279 Ga. 148, 611 S.E.2d 24 (2005).

Notice of accident or loss. — In a policy provision requiring notice to the

insurer "in no event later than 60 days, of how, when and where the accident or loss happened," the 60 day period begins on the date of the accident or loss and not, with respect to uninsured motorist claims, 60 days after discovery of the uninsured status. Manzi v. Cotton States Mut. Ins. Co., 243 Ga. App. 277, 531 S.E.2d 164 (2000).

No "physical contact."

A pedestrian injured as a result of walking into a stationary object located in the back of a parked vehicle cannot obtain uninsured motorist benefits. Corouthers v. Doe, 244 Ga. App. 491, 536 S.E.2d 165 (2000).

No evidence of physical contact and no corroborating evidence. — Insurer was properly granted summary judgment in an insured's action for uninsured motorist coverage where there was no evidence of actual physical contact between the insured and an unknown driver, who allegedly struck either a manhole cover or the bottom of a construction barrel that then struck the insured's car, nor was there any corroborating eyewitness evidence. Hambrick v. State Farm Fire & Cas. Co., 260 Ga. App. 266, 581 S.E.2d 299 (2003).

Existence of non-contacting vehicle corroborated. — In a wrongful death case where a second vehicle rear-ended the car in which the decedent was riding after a third car driven by an unknown person abruptly turned, the trial court did not err in denying an insurer's motion for directed verdict and motion for judgment notwithstanding the verdict. Although the third car had no contact with the vehicle in which the decedent was riding, numerous eyewitnesses corroborated the existence of the third car and testified that it was at least to some degree responsible for the accident; furthermore, there was evidence from which the jury could conclude that the third driver was 90 percent negligent in causing the accident. State Farm v. Nelson, 296 Ga. App. 47, 673 S.E.2d 588 (2009).

Impact on complete compensation doctrine from Medicare payment. — A trial court erred by dismissing an insured's uninsured motorist (UM) benefits suit against the insured's UM carrier as the insured's settlement with the tortfeasor was reduced by the amount of a Medicare lien; therefore, the insured's UM recovery should not have been reduced (nor rejected) under the complete compensation doctrine. Toomer v. Allstate Ins. Co., 292 Ga. App. 60, 663 S.E.2d 763 (2008).

Effect of failure to report accident as required by O.C.G.A. § 40-6-273. — Motorcyclist's failure to report involvement in a collision to the police for 29 days violated O.C.G.A. § 40-6-273, which was a condition precedent to uninsured motorist coverage under O.C.G.A. § 33-7-11(c); summary judgment to the insurer was properly granted. Pender v. Doe, 276 Ga. App. 178, 622 S.E.2d 888 (2005).

Punitive damages not permitted.

The trial court did not err in granting partial summary judgment to an uninsured motorist (UM) insurance provider because the UM provider was not statutorily obligated under O.C.G.A. § 33-7-11(a)(1) to pay a punitive damages judgment in the event that one was awarded to the insureds; no recovery of punitive damages could be had against a UM provider. Bonamico v. Kisella, 290 Ga. App. 211, 659 S.E.2d 666 (2008).

Penalties and attorney fees. — Insured who tried to recover damages for injuries the insured sustained in a motor vehicle accident in Florida, but who alleged that the insured's claim was denied because the insured did not have the right to sue under Florida's no-fault statute, was entitled to collect uninsured motorist benefits from the insured's own insurance company, pursuant to O.C.G.A. § 33-7-11. However, the trial court, which heard the insured's action against the insured's insurance company, erred when it denied the company's motion for summary judgment on the insured's claim seeking penalties and attorney fees, pursuant to O.C.G.A. § 33-4-6, because the case presented a unique issue of law and there was no evidence that the company acted in bad faith when it denied the insured's claim. Ga. Farm Bureau Mut. Ins. Co. v. Williams, 266 Ga. App. 540, 597 S.E.2d 430 (2004).

Because an insured's bad faith claim was based upon a tortfeasor's conduct, the insured did not incur attorney's fees and

expenses because of the bodily injury or property damage that the insured sustained; thus, pursuant to the plain language of O.C.G.A. § 33-7-11(b)(1)(D)(ii), the insured could not recover attorney's fees and expenses from the insured's uninsured motorist insurer under O.C.G.A. § 13-6-11. Smith v. Stoddard, 294 Ga. App. 679, 669 S.E.2d 712 (2008).

Attempt at service requires due diligence. — Because there was no evidence of any effort to locate or serve driver of vehicle for three months between the initial failed attempt and the insurance company's motion to dismiss, the trial court did not abuse its discretion in finding a lack of due diligence. Brown v. State Farm Mut. Auto. Ins. Co., 242 Ga. App. 313, 529 S.E.2d 439 (2000).

Cited in Southeastern Sec. Ins. Co. v. Lowe, 242 Ga. App. 535, 530 S.E.2d 231 (2000); Allstate Ins. Co. v. Baldwin, 244 Ga. App. 664, 536 S.E.2d 558 (2000); Hudson v. Whited, 250 Ga. App. 451, 552 S.E.2d 447 (2001); Woody v. Georgia Farm Bureau Mut. Ins. Co., 250 Ga. App. 454, 551 S.E.2d 837 (2001); Horace Mann Ins. Corp. v. Mercer, 257 Ga. App. 278, 570 S.E.2d 589 (2002); Dunn v. Kirsten, 273 Ga. App. 27, 614 S.E.2d 156 (2005); Williams v. Jackson, 273 Ga. App. 207, 614 S.E.2d 828 (2005); Butler v. Gary, Williams, Parenti, Finney, Lewis, McManus, Watson & Sperando, P.L., 280 Ga. App. 207, 633 S.E.2d 614 (2006); McClellan v. Evans, 294 Ga. App. 595, 669 S.E.2d 554 (2008).

Who Is Covered

Owner, spouse, and relatives in household covered whether or not in insured car.

When a wife's insurance policy on a couple's jointly owned car was cancelled for nonpayment, after which the car was involved in an accident, the car was not an uninsured vehicle under the husband's policy, which excluded a vehicle "furnished for the regular use of you, your spouse or any relative." The policy complied with O.C.G.A. § 33-7-11(a)(1) because the insurer agreed to provide coverage within the statutory limits and with § 33-7-11(b)(1)(B) because the wife was included as an insured as the husband's spouse. Zilka v. State Farm Mut. Auto. Ins. Co., 291 Ga. App. 665, 662 S.E.2d 777 (2008).

Listed driver not named insured. — Driver who was a listed driver on a friend's insurance policies was not entitled to stack the friend's policies under the first category of O.C.G.A. § 33-7-11(b)(1)(B). Listed drivers were not named insureds; thus, because the driver was neither the friend's relative nor a named insured, the driver was not an insured under the first category of § 33-7-11(b)(1)(B). Dunn-Craft v. State Farm Mut. Ins. Co., 314 Ga. App. 620, 724 S.E.2d 903 (2012).

Stacking not permitted for vehicles not involved in accident. — Driver who was a listed driver on a friend's insurance policies was not entitled to stack the friend's policies under the second category of O.C.G.A. § 33-7-11(b)(1)(B). Because the driver was outside of the vehicle when the driver was struck, there was a genuine issue of material fact as to whether the vehicle was involved, but even if the jury found that the vehicle was involved, the driver would be limited to recovering uninsured motorist (UM) coverage only under the policy covering that vehicle and was not eligible to stack the friend's remaining UM policies on other vehicles. Dunn-Craft v. State Farm Mut. Ins. Co., 314 Ga. App. 620, 724 S.E.2d 903 (2012).

Vehicle dealer's customer. — Unambiguous provisions of a used vehicle dealer's insurance policy provided that the dealer's customer, who had borrowed a car while the customer's car was repaired, was an insured under the policy but was only insured up to the compulsory legal limits of O.C.G.A. § 33-7-11. Because the car was not rented, the provisions of O.C.G.A. § 40-9-102 did not apply. Grange Mut. Cas. Co. v. Fulcher, 306 Ga. App. 109, 701 S.E.2d 547 (2010).

Corporate employer, not employee driver, was named insured for stacking purposes. — Appellate court erred in concluding that a driver was entitled to stack the uninsured motorist coverage from the driver's employer's insurance policies which covered vehicles that were not involved in the car accident in which the driver was injured under O.C.G.A. § 33-7-11(b)(1)(B), because the driver was

not the "named insured." Rather, the corporate employer was the named insured. State Farm Mut. Auto. Ins. Co. v. Staton, 286 Ga. 23, 685 S.E.2d 263 (2009).

Students. — Student injured when struck by an uninsured pick-up driver while crossing a highway to board a school bus was an insured user of the bus entitled to uninsured motorist coverage under the school board's insurance policy. The Georgia uninsured motorist statute, O.C.G.A. § 33-7-11, provided that an insured was anyone who, with the insured's consent, used an insured vehicle. State Farm Mut. Auto Ins. Co. v. Vaughn, 253 Ga. App. 217, 558 S.E.2d 769 (2002).

Who Is "Uninsured Motorist"

"Uninsured motor vehicle".

In a case involving insurance coverage after an accident, O.C.G.A. § 33-7-11(b)(1)(D)(ii) did not apply to the vehicle driven by a first tortfeasor or the vehicle driven by another tortfeasor; the first tortfeasor was not underinsured, and the second tortfeasor had no available insurance, placing the second tortfeasor's vehicle within O.C.G.A. § 33-7-11(b)(1)(D)(i). Nationwide Mut. Ins. Co. v. Boylan, 263 Ga. App. 723, 589 S.E.2d 280 (2003).

Effect of payments to subrogation claimants. — Defendant insurer was properly granted summary judgment on a claim by plaintiffs, a postal worker and spouse, for underinsured motorist benefits in a case where plaintiffs received $95,554 from the tortfeasor who injured the postal worker, representing the tortfeasor's cumulative policy limits of $100,000 less $4,445 which was paid to the postal service for damage to a postal truck, because, even though $34,666 of the $95,554 went to a workers' compensation program and a health insurer on their subrogation claims, the subrogation sums represented money that the postal worker had already recovered in the form of workers' compensation and health benefits coverage for some of the worker's damages; thus, the subrogation claims did not constitute "payment of other claims or otherwise" which reduced the tortfeasor's available coverage, plaintiffs recovered more than their available $75,000 in uninsured/underinsured motorist coverage, and the trial court was correct that the tortfeasor was not underinsured for purposes of O.C.G.A. § 33-7-11(b)(1)(D)(ii). Thurman v. State Farm Mut. Auto. Ins. Co., 260 Ga. App. 338, 579 S.E.2d 746 (2003).

"John Doe" action authorized if either owner or operator unknown. — Even though plaintiff knew the identity of the registered owner of the vehicle that hit him before he filed his lawsuit, because he did not see, and did not know, who was driving the vehicle at the time of the collision, he properly filed a "John Doe" action under the alternative language of the uninsured motorist statute. Finch v. Doe, 247 Ga. App. 298, 543 S.E.2d 105 (2000).

Evidence of unknown owner or operator.

Physical contact required for an uninsured motorist claim was not met where the injured person's van was struck by cargo being hauled by an unknown motorist's truck; only admissible evidence satisfied the statutory corroboration requirement, and where out of court statements made by the injured person's late husband were inadmissible, summary judgment in favor of the insurance carrier on the injured person's uninsured motorist claim was affirmed. Torstenson v. Doe, 257 Ga. App. 389, 571 S.E.2d 432 (2002).

Action against unidentified driver. — Parent who filed a wrongful death action against an unidentified driver after the child's body was found by the side of a road presented no evidence that the unidentified driver was negligent or that the driver's actions caused the decedent's death, and the appellate court affirmed the trial court's judgment granting a motion for summary judgment which was filed by an insurance company that provided uninsured motorist coverage. Dawkins v. Doe, 263 Ga. App. 737, 589 S.E.2d 303 (2003).

Refusal to Pay Loss

Legal denial of coverage not found. — Because the faulted driver's policy limits had been exhausted, due in part by a $450,000 payment to a suing plaintiff, the denial of any further coverage by that plaintiff's uninsured motorist insurer did

not amount to a legal denial of coverage under O.C.G.A. § 33-7-11(b)(1)(D)(iii). Thus, the uninsured motorist's insurer was properly granted summary judgment on that issue. Phillips v. Gov't Emples. Ins. Co., 288 Ga. App. 504, 654 S.E.2d 635 (2007).

Waiver of Coverage

Waiver of excess coverage not required. — An insured did not retain the right to receive excess uninsured motorist coverage after an accident, notwithstanding that the insured had not previously executed a written rejection of such excess coverage, since the statute only requires an insurer to obtain a written rejection of minimum coverage and does not require an insurer to obtain a written rejection of excess coverage. Jones v. Georgia Farm Bureau Mut. Ins. Co., 248 Ga. App. 394, 546 S.E.2d 791 (2001).

Excess coverage was never requested. — Conclusion that an insurer was only obligated to provide its insured with $40,000 of uninsured motorist (UM) coverage was supported by both the unambiguous policy language and by the fact that the insured admitted that the insured had not made a written request pursuant to former O.C.G.A. § 33-7-11(a)(3) for an increase in UM coverage above the minimum coverage required at the time of the accident. Payne v. Middlesex Ins. Co., 259 Ga. App. 867, 578 S.E.2d 470 (2003).

Waiver requirements satisfied. — Under the ordinary rules of contract construction, because: (1) no ambiguity in the insurance contact existed; and (2) the insurer was authorized to reduce the uninsured motorist policy limits per the directions of the insured, no error resulted from the trial court's order granting summary judgment to an insurer as to the issue of coverage. Moreover, separate signatures rejecting bodily injury coverage and property damage coverage were not required, and the court did not rely upon affidavits containing inadmissible evidence. Lambert v. Alfa Gen. Ins. Corp., 291 Ga. App. 57, 660 S.E.2d 889 (2008).

Waiver requirements not satisfied. — Insureds' written rejection of uninsured motorist (UM) coverage under an umbrella policy was not valid because, while the insureds were aware of the possibility of obtaining such coverage, the insureds were misinformed that, in order to obtain such coverage, the insureds had to increase the limits of the insureds' UM coverage in the insureds' primary liability policies to equal the limits of the policies' bodily injury and property damage limits, contrary to the then existing requirement that the umbrella policy be treated the same as primary automobile liability insurance policies as to statutory requirements governing UM coverage. Ga. Farm Bureau Mut. Ins. Co. v. North, 311 Ga. App. 281, 714 S.E.2d 428 (2011).

Insureds' written rejection of uninsured motorist (UM) coverage under an umbrella policy was not valid because it appeared from the wording of the umbrella policy application that if the insureds chose not to increase the insureds' primary liability policies' UM coverage limits, the insureds could only reject UM coverage, but an insurer could not fail to offer coverage options which the statute required, or impose coverage conditions the law did not allow, and the statutory coverage options were not offered to the insureds when the insureds did not increase the insureds' UM primary policy coverage limits to equal those policies' liability coverage limits. Ga. Farm Bureau Mut. Ins. Co. v. North, 311 Ga. App. 281, 714 S.E.2d 428 (2011).

Procedure

The trial court properly denied a plaintiff's motion to serve by publication under O.C.G.A. § 33-7-11(e) on the basis of self-concealment to avoid service. A finding of concealment required more than evidence that the defendant simply could not be located or had moved to a new location, and the plaintiff's affidavit reflected only that efforts to locate the defendant had been unsuccessful. Montague v. Godfrey, 289 Ga. App. 552, 657 S.E.2d 630 (2008).

Underlying judgment required before a UIM claim may be made. — Trial court properly granted summary judgment to an insurer on uninsured motorist claims, O.C.G.A. § 33-7-11, because the injured parties' failure to promptly effect service of process precluded any judgment

against the uninsured driver. Cohen v. Allstate Ins. Co., 277 Ga. App. 437, 626 S.E.2d 628 (2006).

Statute of limitations.

Plaintiff's service of defendant's uninsured motorist insurer was untimely under O.C.G.A. § 33-7-11(d); the record did not support the plaintiff's claim that plaintiff served the insurer within 90 days of discovery that the defendant's vehicle, which the plaintiff allegedly initially had no reason to believe was uninsured, was uninsured. Rebuelta v. Nkpa, 281 Ga. App. 210, 636 S.E.2d 42 (2006).

Because an insured did not serve a copy of an underinsured motorist complaint upon the insurer within the two year statute of limitations in O.C.G.A. § 9-3-33 or within 90 days of receiving the discovery responses indicating that the vehicle that hit the insured's vehicle was underinsured, the insured did not satisfy the service requirement of O.C.G.A. § 33-7-11(d). Calhoun v. Gov't Emples. Ins. Co., 296 Ga. App. 622, 675 S.E.2d 523 (2009).

Two-year statute of limitations applies to suit against uninsured motorist.

Service on an uninsured motorist carrier in a valid renewal action filed after the running of the statute of limitations is valid even though the carrier was not served in the original action. Malave v. Allstate Ins. Co., 246 Ga. App. 783, 541 S.E.2d 420 (2000).

No suit against carrier if judgment had not been obtained from uninsured motorist. — Dismissal of the insured's renewal action for personal injuries was proper because the uninsured motorist was properly dismissed based upon a lack of personal service in the original action before the expiration of the statute of limitation and the dismissal against the carrier was proper because no judgment could be obtained against the motorist. A judgment against the uninsured motorist was a condition precedent to recovery against an uninsured motorist carrier under O.C.G.A. § 33-7-11(a)(1). Durrah v. State Farm Fire & Cas., 312 Ga. App. 49, 717 S.E.2d 554 (2011).

Bad faith claim against insurer. — Bad faith claim against the insurer had to be filed in a separate action after the plaintiffs obtained a judgment against the opposing driver. Morton v. Horace Mann Ins. Co., 282 Ga. App. 734, 639 S.E.2d 352 (2006), cert. denied, 2007 Ga. LEXIS 201 (Ga. 2007).

Enforcement of policy exclusions permitted despite public policy in favor of coverage. — Enforcement of exclusions in a car rental agency agreement did not conflict with Georgia's public policy in favor of compulsory insurance coverage because an accident victim received compensation from the car renter's insurer and from the victim's own insurer in excess of the compulsory minimum amount required by O.C.G.A. § 33-7-11(a)(1)(A). Hix v. Hertz Corp., 307 Ga. App. 369, 705 S.E.2d 219 (2010).

By filing pleadings in its own behalf.

In insureds' suit seeking to recover damages in connection with an accident in which a daughter struck the insureds' vehicle while driving a car that was titled in the father's name, the insureds' motor vehicle insurer chose to file pleadings in its own name, and thus, under O.C.G.A. § 33-7-11(d), the insurer had assumed the status of a named party, even though the insurer was not originally named as a party to the action. Harris v. Houston, No. 4:04-cv-159 (HL), 2006 U.S. Dist. LEXIS 69099 (M.D. Ga. Sept. 26, 2006).

Required pleading. — Because plaintiff insured number one never attempted to sue the uninsured motorists (UM) motorist in plaintiff's accident, and plaintiff insured number two dismissed plaintiff two's suit against the UM in settling with defendant insurer, their direct action claim against the insurer was barred since neither insured pled the possibility that the insurer waived O.C.G.A. § 33-7-11's condition precedent. Harden v. State Farm Mut. Auto. Ins. Co., No. 08-15008, 2009 U.S. App. LEXIS 16095 (11th Cir. July 22, 2009) (Unpublished).

Subrogation rights of uninsured motorist insurer.

Filing a cross-claim pursuant to subsection (f) is simply a means of perfecting an insurer's subrogation right in the event that a judgment is obtained against the uninsured motorist. State Farm Mut. Auto. Ins. Co. v. Wright, 245 Ga. App. 493, 538 S.E.2d 147 (2000).

The subrogation claim under subsection (f) does not ripen until the judgment is satisfied. State Farm Mut. Auto. Ins. Co. v. Wright, 245 Ga. App. 493, 538 S.E.2d 147 (2000).

Injured insured's uninsured motorist insurer could sue a tortfeasor in subrogation as provided in O.C.G.A. § 33-7-11(f) even after the insured had released the tortfeasor from personal liability, pursuant to O.C.G.A. § 33-24-41.1, except to the extent that insurance coverage, other than the tortfeasor's personal liability policy, existed. Ramos-Silva v. State Farm Mut. Ins. Co., 300 Ga. App. 699, 686 S.E.2d 345 (2009).

Service requirement of subsection (d), etc.

Injured party's claim for uninsured motorist benefits was dismissed where the injured party, after failing to perfect service as to the driver, incurred the heightened obligation of exercising the greatest possible diligence to ensure proper and timely service when the insurer raised the defense of defective service, but failed to seek a special process server immediately and failed to move for service by publication until almost two months later. Barabont v. Villanueva, 261 Ga. App. 839, 584 S.E.2d 74 (2003).

When insured brought suit against a driver for negligence, but did not serve the insured's excess uninsured motorist (UM) carrier under O.C.G.A. § 33-7-11 until after renewing the suit under O.C.G.A. § 9-2-61, it was error to grant summary judgment to the excess carrier on ground that service was untimely; purpose of § 33-7-11(d) is to provide notice to a UM carrier, not to obtain personal jurisdiction over it or to make it a party defendant, and service on a UM carrier was permissible at any time within which valid service could be made on the defendant. Hayward v. Retention Alternatives, Ltd., 291 Ga. App. 232, 661 S.E.2d 862 (2008), aff'd, Retention Alternatives, Ltd. v. Hayward, 285 Ga. 437, 678 S.E.2d 877 (2009).

Provision for service by publication applies where tort-feasor cannot be found.

Trial court erroneously dismissed the insured party's uninsured motorist action against the insurer; the insured party, by attempting service twice, showed due diligence under O.C.G.A. § 33-7-11(e) in determining that the defendant, who allegedly struck the insured party, had either had departed from the state or could not, after due diligence, be found within the state, the insured party made all three requests for service by publication before the statute of limitations under O.C.G.A. § 9-3-33 expired, and the latter two requests were pending for decision by the trial court for more than three months in violation of O.C.G.A. § 15-6-21(b). Luca v. State Farm Mut. Auto. Ins. Co., 281 Ga. App. 658, 637 S.E.2d 86 (2006).

Insurer timely filed in insured's renewal action. — Uninsured motorist (UM) insurer was timely served in an insured's renewal action, and summary judgment for the insurer was error because service on a UM carrier under O.C.G.A. § 33-7-11 was valid and timely within any time allowed for valid service on the tortfeasor in the case, even if such valid service was after the expiration of the statute of limitation; nothing in the 1998 amendment to § 33-7-11 reflected a legislative decision to overrule any of the judicial decisions holding such service valid. Although the insured had voluntarily dismissed the initial suit, the insured timely renewed the action pursuant to O.C.G.A. § 9-2-61, and served the insurer with the renewed complaint. Retention Alternatives, Ltd. v. Hayward, 285 Ga. 437, 678 S.E.2d 877 (2009).

Evidence supported a finding that plaintiff failed to exercise due diligence, etc.

As car owners did not show that they acted with the greatest possible diligence to serve an allegedly uninsured driver who caused a vehicle collision after the owners' uninsured motorist insurer asserted a defense of insufficient service on the driver under O.C.G.A. § 33-7-11(d), the insurer should have been granted summary judgment; after assertion of that defense, which was made after the expiration of the limitations period under O.C.G.A. § 9-3-33, there were months-long delays by the owners in obtaining an order for service by publication, and in then serving the driver in that manner.

State Farm Mut. Auto. Ins. Co. v. Manders, 292 Ga. App. 793, 665 S.E.2d 886 (2008).

Passenger's personal injury action against a driver renewed pursuant to O.C.G.A. § 9-2-61 was dismissed for failure to perfect service of process against the driver due to lack of diligence. Although the passenger attempted to serve the driver for several months, the passenger then allowed 72 days to elapse before making another attempt. The court rejected the passenger's contention that O.C.G.A. § 33-7-11, providing for personal service after service of publication while allowing litigation against an uninsured motorist carrier to proceed, allowed for an additional 12 months after service by publication. Williams v. Patterson, 306 Ga. App. 624, 703 S.E.2d 74 (2010).

Conflicting eyewitness testimony. Judgment denying an insurer's summary judgment motion was improper, in an action for uninsured motorist benefits under O.C.G.A. § 33-7-11, due to the absence of eyewitness evidence corroborating an allegation by a decedent's spouse that the driver of an unknown vehicle negligently caused the subject accident; although three of the four witnesses deposed established the presence of an unknown vehicle, each described the vehicle in a different location, and none corroborated the spouse's description of how the occurrence occurred. Bituminous Ins. Co. v. Coker, 314 Ga. App. 30, 722 S.E.2d 879 (2012).

Eyewitness corroboration is required. Trial court properly granted summary judgment to an insurer in an action by an insured, seeking uninsured motorist coverage pursuant to O.C.G.A. § 33-7-11, as the vehicle in front of the insured had swerved to avoid a ladder in the highway, which set off the chain of reactions that resulted in the insured's collision and injuries, but there was no witness testimony as to how the ladder ended up in the roadway; there was no testimony from the insured or from any other eyewitness that the ladder had been negligently secured to a vehicle and that it had fallen into the roadway from the unknown vehicle, such that coverage was properly denied in the circumstances. Hohman v. State Farm Fire & Cas. Auto. Ins. Co., 283 Ga. App. 430, 641 S.E.2d 650 (2007).

Service by publication alone was insufficient for the trial court to obtain personal jurisdiction over an individual and for an injured party to obtain a personal judgment against the individual. Williams v. Jackson, 273 Ga. App. 207, 614 S.E.2d 828 (2005).

Summary judgment in favor of mother's insurer reversed. — Trial court erred by granting summary judgment to a mother's insurer in a suit wherein a driver, a child, claimed residency at both parents' homes with regard to underinsured motorist coverage because a genuine issue of material fact existed as to whether the driver resided at both homes. Daniel v. Allstate Ins. Co., 290 Ga. App. 898, 660 S.E.2d 765 (2008), cert. denied, 2008 Ga. LEXIS 698 (Ga. 2008).

RESEARCH REFERENCES

ALR. — Uninsured motorist indorsement: construction and application of requirement that there be "physical contact" with unidentified or hit-and-run vehicle; "miss-and-run" cases, 77 ALR5th 319.

Uninsured motorist indorsement: general issues regarding requirement that there be "physical contact" with unidentified or hit-and-run vehicle, 78 ALR5th 341.

Uninsured motorist indorsement: construction and application of requirement that there be "physical contact" with unidentified or hit-and-run vehicle; "hit-and-run" cases, 79 ALR5th 289.

Conduct or inaction by insurer constituting waiver of, or creating estoppel to assert, right of subrogation, 125 ALR5th 1.

33-7-11.1. Commencement of liability of insurer to pay benefits to third party on behalf of insured; applicability of Code section.

(a) As used in this Code section, the term "liability insurance policy" means an automobile liability or motor vehicle liability insurance policy issued or delivered in this state to the owner of such vehicle or issued or delivered by any insurer licensed in this state upon any such motor vehicle then principally garaged or principally used in this state.

(b) Any insurer, upon acceptance of liability, pursuant to any automobile liability or motor vehicle liability insurance policy, shall pay reasonable benefits for losses, including total losses, to a third party on behalf of an insured for loss of use and towing and storage costs of such a motor vehicle, and the liability of the insurer for payment of benefits for losses, including total losses, to the third party shall commence as of the time of the incident or occurrence which results in such losses; provided, however, in no event shall this Code section be construed so as to relieve the claimant of his or her obligation to mitigate his or her losses or to require the payment of loss of use and towing and storage costs benefits in an amount which is greater than the actual losses suffered.

(c) When making any payment to a third party for damage to an automobile for any loss, the insurer shall have printed on the loss estimate, if prepared directly by the insurer, the following:

> "Failure to use the insurance proceeds in accordance with a security agreement between you and a lienholder, if any, may be a violation of Code Section 16-8-4 of the O.C.G.A. If you have any questions, contact your lending institution."

This subsection does not apply if the insurer does not prepare the loss estimate or if the estimate is not prepared in the State of Georgia.

(d) The provisions of this Code section shall be applicable to all automobile liability or motor vehicle liability insurance policies that pay benefits to a third party on behalf of an insured for the loss of use and towing and storage costs of such motor vehicle issued, delivered, or renewed in this state on or after January 1, 2009. (Code 1933, § 56-407B, enacted by Ga. L. 1982, p. 802, § 1; Code 1981, § 33-7-11.1, enacted by Ga. L. 1982, p. 802, § 2; Ga. L. 2002, p. 1192, § 1; Ga. L. 2003, p. 140, § 33; Ga. L. 2008, p. 828, § 1/HB 673.)

The 2002 amendment, effective July 1, 2002, rewrote subsection (b); and, in subsection (c), substituted "that" for "pursuant to which an insurer undertakes to", inserted "and towing and storage costs" and substituted "July 1, 2002" for "November 1, 1982".

The 2003 amendment, effective May 14, 2003, part of an Act to revise, modernize, and correct the Code, substituted "sec-

tion, the term 'liability insurance policy'" for "section, 'liability insurance policy'" near the beginning of subsection (a).

The 2008 amendment, effective July 1, 2008, added subsection (c); redesignated former subsection (c) as present subsection (d); and substituted "January 1, 2009" for "July 1, 2002" at the end of subsection (d).

33-7-12. Effect of provision in policy permitting insurer to settle or compromise claims upon rights of insured and of third persons; settlement of claims by third persons.

Law reviews. — For survey article on insurance law, see 59 Mercer L. Rev. 195 (2007).

JUDICIAL DECISIONS

Insurer has no right of subrogation for payments made without insured's consent.

Under O.C.G.A. § 33-7-12(a), a general contractor's insurer had no right to indemnification as a subrogee with regard to settlements paid to certain plaintiffs in an underlying personal injury suit; because the settlement payments had been made without the general contractor's consent, the insurer had made the settlement payments not as an insurer but as an independent contractor. BBL-McCarthy, LLC v. Baldwin Paving Co., 285 Ga. App. 494, 646 S.E.2d 682 (2007), cert. denied, 2007 Ga. LEXIS 621, 631, 661 (Ga. 2007).

Pursuant to O.C.G.A. § 33-7-12(a), subcontractors were not liable to an insurer for their share of funds paid in settlement of a homeowner's faulty construction claim against the insurer, a contractor, because the insurer settled the homeowner's claim without obtaining the insured's singed consent to the settlement. Mandato & Assocs., Inc. v. Masonry, 303 Ga. App. 438, 693 S.E.2d 620 (2010).

Cited in Weaver v. Reed, 282 Ga. App. 831, 640 S.E.2d 351 (2006).

RESEARCH REFERENCES

Am. Jur. Pleading and Practice Forms. — 14A Am. Jur. Pleading and Practice Forms, Insurance, § 67.

ALR. — Conduct or inaction by insurer constituting waiver of, or creating estoppel to assert, right of subrogation, 125 ALR5th 1.

33-7-14. Reinsurance of risks.

(a) Credit for reinsurance shall be allowed a domestic ceding insurer as either an asset or a deduction from liability on account of reinsurance ceded only when the reinsurer meets the requirements of paragraph (1), (2), (3), (4), (5), or (6) of this subsection. Credit shall be allowed under paragraph (1), (2), or (3) of this subsection only with respect to cessions of those kinds of classes of business for which the assuming insurer is licensed or otherwise permitted to write or assume in its state of domicile, or in the case of a United States branch of an alien assuming insurer, in the state through which it is entered and licensed to transact insurance or reinsurance. If meeting the require-

ments of paragraph (3) or (4) of this subsection, the requirements of paragraph (7) of this subsection shall also be met:

(1) Credit shall be allowed when the reinsurance is ceded to an assuming insurer which is licensed to transact insurance or reinsurance in this state;

(2) Credit shall be allowed when the reinsurance is ceded to an assuming insurer which is accredited as a reinsurer by the Commissioner in this state. In order to be eligible for accreditation, a reinsurer shall:

(A) File with the Commissioner evidence of its submission to this state's jurisdiction;

(B) Submit to this state's authority to examine its books and records;

(C) Be licensed to transact insurance or reinsurance in at least one state, or in the case of a United States branch of an alien assuming insurer, be entered through and licensed to transact insurance or reinsurance in at least one state;

(D) File annually with the Commissioner a copy of its annual statement filed with the insurance department of its state of domicile and a copy of its most recent audited financial statement; and

(E) Demonstrate to the satisfaction of the Commissioner that it has adequate financial capacity to meet its reinsurance obligations and is otherwise qualified to assume reinsurance from domestic insurers. An assuming insurer is deemed to meet this requirement as of the time of its application if it maintains a surplus as regards policyholders in an amount of not less than $20 million and its accreditation has not been denied by the Commissioner within 90 days after the submission of its application;

(3) Credit shall be allowed when the reinsurance is ceded to an assuming insurer which is domiciled and licensed in, or, in the case of a United States branch of an alien assuming insurer, is entered through a state which employs standards regarding credit for reinsurance substantially similar to those applicable under this Code section and the assuming insurer or United States branch of an alien assuming insurer:

(A) Maintains a surplus with regard to policyholders in an amount not less than $20 million; and

(B) Submits to the authority of this state to examine its books and records. Subparagraph (A) of this paragraph shall not apply to

reinsurance ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system;

(4)(A) Credit shall be allowed when the reinsurance is ceded to an assuming insurer which maintains a trust fund in a qualified United States financial institution, as defined in subsection (c) of this Code section, for the payment of the valid claims of its United States ceding insurers, their assigns, and successors in interest. The assuming insurer shall report annually to the Commissioner information substantially the same as that required to be reported on the National Association of Insurance Commissioners Annual Statement form by licensed insurers to enable the Commissioner to determine the sufficiency of the trust fund. In the case of a single assuming insurer, the trust shall consist of a trusteed account representing the assuming insurer's liabilities attributable to business written in the United States and, in addition, the assuming insurer shall maintain a trusteed surplus of not less than $20 million; provided, however, that, at any time after the assuming insurer has permanently discontinued underwriting new business secured by trust for at least three full years, the commissioner with principal regulatory oversight of the trust may authorize a reduction of the required trusteed surplus, but only after a finding, based upon an assessment of the risk, that the new required surplus level is adequate for the protection of United States ceding insurers, policyholders, and claimants in light of reasonably foreseeable adverse loss development. The risk assessment may involve an actuarial review, including an independent analysis of reserves and cash flows, and shall consider all material risk factors, including, when applicable, the lines of business involved, the stability of the incurred loss estimates and the effect of the surplus requirements on the assuming insurer's liquidity or solvency. The minimum required trusteed surplus may not be reduced to an amount less than 30 percent of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers covered by the trust. In the case of a group including incorporated and individual unincorporated underwriters, the trust shall consist of a trusteed account in an amount not less than the respective underwriters' liabilities attributable to business written in the United States and, in addition, the group shall maintain a trusteed surplus of which $100 million shall be held jointly for the benefit of United States ceding insurers of any member of the group for all years of account; the incorporated members of the group shall not be engaged in any business other than underwriting as a member of the group and shall be subject to the same level of solvency regulation and control by the group's domiciliary regulator as are the unincorporated members; and, within 90 days after its finan-

cial statements are due to be filed with the group's domiciliary regulator, the group shall provide to the Commissioner an annual certification of the solvency of each underwriter by the group's domiciliary regulator or, if a certification is unavailable, financial statements prepared by independent public accountants of each member of the group.

(B) In the case of a group of incorporated insurers under common administration which complies with the filing requirements contained in subparagraph (A) of this paragraph and which has continuously transacted an insurance business outside the United States for at least three years immediately prior to making application for accreditation, and submits to this state's authority to examine its books and records and bears the expense of the examination, and which has aggregate policyholders' surplus of $10 billion; the trust shall be in an amount equal to the group's several liabilities attributable to business ceded by the United States ceding insurers to any member of the group pursuant to reinsurance contracts issued in the name of such group; plus the group shall maintain a joint trusteed surplus of which $100 million shall be held jointly for the benefit of United States ceding insurers of any member of the group as additional security for any such liabilities, and within 90 days after its financial statements are due to be filed with the group's domiciliary regulator, each member of the group shall make available to the Commissioner an annual certification of the member's solvency by the member's domiciliary regulator and financial statements prepared by its independent public accountant.

(C) Credit for reinsurance shall not be granted under this paragraph unless the form of the trust and any amendments to the trust have been approved by the commissioner of the state where the trust is domiciled or the commissioner of another state, who, pursuant to the terms of the trust agreement, has accepted principal regulatory oversight of the trust. The form of the trust and any trust amendments also shall be filed with the commissioner of every state in which the ceding insurer beneficiaries of the trust are domiciled. The trust instrument shall provide that contested claims shall be valid and enforceable upon the final order of any court of competent jurisdiction in the United States. The trust shall vest legal title to its assets in the trustees of the trust for its United States ceding insurers, their assigns, and successors in interest. The trust and the assuming insurer shall be subject to examination as determined by the Commissioner. The trust must remain in effect for as long as the assuming insurer shall have outstanding obligations due under the reinsurance agreements subject to the trust.

(D) No later than February 28 of each year the trustees of the trust shall report to the Commissioner in writing setting forth the balance of the trust and listing the trust's investments as of the end of the preceding year and shall certify the date of termination of the trust, if so planned, or certify that the trust shall not expire prior to the next following December 31;

(5) Credit shall be allowed when the reinsurance is ceded to an assuming insurer not meeting the requirements of paragraph (1), (2), (3), or (4) of this subsection if such assuming insurer has been certified by the Commissioner as a reinsurer in this state and secures its obligations in accordance with the requirements of this subsection.

(A) In order to be eligible for certification, the assuming insurer shall meet the following requirements:

(i) The assuming insurer shall be domiciled and licensed to transact insurance or reinsurance in a qualified jurisdiction, as determined by the Commissioner pursuant to subparagraph (C) of this paragraph;

(ii) The assuming insurer shall maintain minimum capital and surplus, or its equivalent, in an amount to be determined by the Commissioner pursuant to regulation;

(iii) The assuming insurer shall maintain financial strength ratings from two or more rating agencies deemed acceptable by the Commissioner pursuant to regulation;

(iv) The assuming insurer shall agree to submit to the jurisdiction of this state, appoint the Commissioner as its agent for service of process in this state, and agree to provide security for 100 percent of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers if it resists enforcement of a final United States judgment;

(v) The assuming insurer shall agree to meet applicable information filing requirements as determined by the Commissioner, both with respect to an initial application for certification and on an ongoing basis; and

(vi) The assuming insurer shall satisfy any other requirements for certification deemed relevant by the Commissioner.

(B) An association including incorporated and individual unincorporated underwriters may be a certified reinsurer. In order to be eligible for certification, in addition to satisfying requirements of subparagraph (A) of this paragraph:

(i) The association shall satisfy its minimum capital and surplus requirements through the capital and surplus equiva-

lents, net of liabilities, of the association and its members, which shall include a joint central fund that may be applied to any unsatisfied obligation of the association of any of its members, in an amount determined by the Commissioner to provide adequate protection;

(ii) The incorporated members of the association shall not be engaged in any business other than underwriting as a member of the association and shall be subject to the same level of regulation and solvency control by the association's domiciliary regulator as are the unincorporated members; and

(iii) Within 90 days after its financial statements are due to be filed with the association's domiciliary regulator, the association shall provide to the Commissioner an annual certification by the association's domiciliary regulator of the solvency of each underwriter member; or if a certification is unavailable, financial statements, prepared by independent public accountants, of each underwriter member of the association.

(C) The Commissioner shall create and publish a list of qualified jurisdictions under which an assuming insurer licensed and domiciled in such jurisdiction is eligible to be considered for certification by the Commissioner as a certified reinsurer.

(i) In order to determine whether the domiciliary jurisdiction of a non-United States assuming insurer is eligible to be recognized as a qualified jurisdiction, the Commissioner shall evaluate the appropriateness and effectiveness of the reinsurance supervisory system of the jurisdiction, both initially and on an ongoing basis, and consider the rights, benefits, and the extent of reciprocal recognition afforded by the non-United States jurisdiction to reinsurers licensed and domiciled in the United States. A qualified jurisdiction shall agree to share information and cooperate with the Commissioner with respect to all certified reinsurers domiciled within that jurisdiction. A jurisdiction may not be recognized as a qualified jurisdiction if the Commissioner has determined that the jurisdiction does not adequately and promptly enforce final United States judgments and arbitration awards. Additional factors may be considered in the discretion of the Commissioner.

(ii) A list of qualified jurisdictions shall be published through the National Association of Insurance Commissioners (NAIC) Committee Process. The Commissioner shall consider this list in determining qualified jurisdictions. If the Commissioner approves a jurisdiction as qualified that does not appear on the list of qualified jurisdictions, the Commissioner shall provide thor-

oughly documented justification in accordance with criteria to be developed under regulations.

(iii) United States jurisdictions that meet the requirement for accreditation under the NAIC financial standards and accreditation program shall be recognized as qualified jurisdictions.

(iv) If a certified reinsurer's domiciliary jurisdiction ceases to be a qualified jurisdiction, the Commissioner has the discretion to suspend the reinsurer's certification indefinitely, in lieu of revocation.

(D) The Commissioner shall assign a rating to each certified reinsurer, giving due consideration to the financial strength ratings that have been assigned by rating agencies deemed acceptable to the Commissioner pursuant to regulation. The Commissioner shall publish a list of all certified reinsurers and their ratings.

(E) A certified reinsurer shall secure obligations assumed from United States ceding insurers under this subparagraph at a level consistent with its rating, as specified in regulations promulgated by the Commissioner.

(i) In order for a domestic ceding insurer to qualify for full financial statement credit for reinsurance ceded to a certified reinsurer, the certified reinsurer shall maintain security in a form acceptable to the Commissioner and consistent with the provisions of subsection (b) of this Code section, or in a multibeneficiary trust in accordance with paragraph (4) of this subsection, except as otherwise provided in this paragraph.

(ii) If a certified reinsurer maintains a trust to fully secure its obligations subject to paragraph (4) of this subsection, and chooses to secure its obligations incurred as a certified reinsurer in the form of a multibeneficiary trust, the certified reinsurer shall maintain separate trust accounts for its obligations incurred under reinsurance agreements issued or renewed as a certified reinsurer with reduced security as permitted by this subsection or comparable laws of other United States jurisdictions and for its obligations subject to paragraph (4) of this subsection. It shall be a condition to the grant of certification under this paragraph that the certified reinsurer shall have bound itself, by the language of the trust and agreement with the commissioner with principal regulatory oversight of each such trust account, to fund, upon termination of any such trust account, out of the remaining surplus of such trust any deficiency of any other such trust account.

(iii) The minimum trusteed surplus requirements provided in paragraph (4) of this subsection are not applicable with respect to

a multibeneficiary trust maintained by a certified reinsurer for the purpose of securing obligations incurred under this subsection, except that such trust shall maintain a minimum trusteed surplus of $10 million.

(iv) With respect to obligations incurred by a certified reinsurer under this subparagraph, if the security is insufficient, the Commissioner shall reduce the allowable credit by an amount proportionate to the deficiency, and shall have the discretion to impose further reductions in allowable credit upon finding that there is a material risk that the certified reinsurer's obligations will not be paid in full when due.

(v) For purposes of this subparagraph, a certified reinsurer whose certification has been terminated for any reason shall be treated as a certified reinsurer required to secure 100 percent of its obligations:

(I) As used in this subparagraph, the term "terminated" refers to revocation, suspension, voluntary surrender, and inactive status.

(II) If the Commissioner continues to assign a higher rating as permitted by other provisions of this paragraph, this requirement shall not apply to a certified reinsurer in inactive status or to a reinsurer whose certification has been suspended.

(F) If an applicant for certification has been certified as a reinsurer in an NAIC accredited jurisdiction, the Commissioner shall have the discretion to defer to that jurisdiction's certification, and shall have the discretion to defer to the rating assigned by that jurisdiction, and such assuming insurer shall be considered to be a certified reinsurer in this state.

(G) A certified reinsurer that ceases to assume new business in this state may request to maintain its certification in inactive status in order to continue to qualify for a reduction in security for its in-force business. An inactive certified reinsurer shall continue to comply with all applicable requirements of this paragraph, and the Commissioner shall assign a rating that takes into account, if relevant, the reasons why the reinsurer is not assuming new business;

(6) Credit shall be allowed when the reinsurance is ceded to an assuming insurer not meeting the requirements of paragraph (1), (2), (3), (4) or (5) of this subsection, but only as to the insurance of risks located in jurisdictions where the reinsurance is required by applicable law or regulation of that jurisdiction;

(7) If the assuming insurer is not licensed, accredited, or certified to transact insurance or reinsurance in this state, the credit permitted by paragraphs (3) and (4) of this subsection shall not be allowed unless the assuming insurer agrees in the reinsurance agreements:

(A) That, in the event of the failure of the assuming insurer to perform its obligations under the terms of the reinsurance agreement, the assuming insurer, at the request of the ceding insurer, shall submit to the jurisdiction of any court of competent jurisdiction in any state of the United States, shall comply with all requirements necessary to give the court jurisdiction, and shall abide by the final decision of the court or of any appellate court in the event of an appeal; and

(B) To designate the Commissioner or a designated attorney as its true and lawful attorney upon whom may be served any lawful process in any action, suit, or proceeding instituted by or on behalf of the ceding insurer.

This paragraph is not intended to conflict with or override the obligation of the parties to a reinsurance agreement to arbitrate their disputes, if this obligation is created in the agreement;

(8) If the assuming insurer does not meet the requirements of paragraph (1), (2), or (3) of this subsection, the credit permitted by paragraph (4) or (6) of this subsection shall not be allowed unless the assuming insurer agrees in the trust agreements to the following conditions:

(A) Notwithstanding any other provisions in the trust instrument, if the trust fund is inadequate because it contains an amount less than the amount required by subparagraphs (A) and (B) of paragraph (4) of this subsection, as applicable, or if the grantor of the trust has been declared insolvent or placed into receivership, rehabilitation, liquidation, or similar proceedings under the laws of its state or country of domicile, the trustee shall comply with an order of the commissioner with regulatory oversight over the trust or with an order of a court of competent jurisdiction directing the trustee to transfer to the commissioner with regulatory oversight all of the assets of the trust fund;

(B) The assets shall be distributed by and claims shall be filed with and valued by the commissioner with regulatory oversight in accordance with the laws of the state in which the trust is domiciled that are applicable to the liquidation of domestic insurance companies;

(C) If the commissioner with regulatory oversight determines that the assets of the trust fund or any part thereof are not

necessary to satisfy the claims of the United States ceding insurers of the grantor of the trust, the assets or part thereof shall be returned by the commissioner with regulatory oversight to the trustee for distribution in accordance with the trust agreement; and

(D) The grantor shall waive any right otherwise available to it under United States law that is inconsistent with this provision.

(9) If an accredited or certified reinsurer ceases to meet the requirements for accreditation or certification, the Commissioner may suspend or revoke the reinsurer's accreditation or certification.

(A) The Commissioner shall give the reinsurer notice and opportunity for hearing. The suspension or revocation shall not take effect until after the Commissioner's order on hearing, unless:

(i) The reinsurer waives its right to hearing;

(ii) The Commissioner's order is based on regulatory action by the reinsurer's domiciliary jurisdiction or the voluntary surrender or termination of the reinsurer's eligibility to transact insurance or reinsurance business in its domiciliary jurisdiction or in the primary certifying state of the reinsurer under subparagraph (F) of paragraph (5) of this subsection; or

(iii) The Commissioner finds that an emergency requires immediate action and a court of competent jurisdiction has not stayed the Commissioner's action.

(B) While a reinsurer's accreditation or certification is suspended, no reinsurance contract issued or renewed after the effective date of the suspension qualifies for credit except to the extent that the reinsurer's obligations under the contract are secured in accordance with subsection (b) of this Code section. If a reinsurer's accreditation or certification is revoked, no credit for reinsurance may be granted after the effective date of the revocation except to the extent that the reinsurer's obligations under the contract are secured in accordance with subparagraph (E) of paragraph (5) of this subsection or subsection (b) of this Code section.

(10) Concentration Risk:

(A) A ceding insurer shall take steps to manage its reinsurance recoverable proportionate to its own book of business. A domestic ceding insurer shall notify the Commissioner within 30 days after reinsurance recoverables from any single assuming insurers, or group of affiliated assuming insurers, exceeds 50 percent of the domestic ceding insurer's last reported surplus to policyholders, or

after it is determined that reinsurance recoverables from any single assuming insurer, or group of affiliated assuming insurers, is likely to exceed this limit. The notification shall demonstrate that the exposure is safely managed by the domestic ceding insurer.

(B) A ceding insurer shall take steps to diversify its reinsurance program. A domestic ceding insurer shall notify the Commissioner within 30 days after ceding to any single assuming insurer, or group of affiliated assuming insurers, more than 20 percent of the ceding insurer's gross written premium in the prior calendar year, or after it has determined that the reinsurance ceded to any single assuming insurer, or group of affiliated assuming insurers, is likely to exceed this limit. The notification shall demonstrate that the exposure is safely managed by the domestic ceding insurer.

(b) An asset or a reduction from liability for the reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of subsection (a) of this Code section shall be allowed in an amount not exceeding the liabilities carried by the ceding insurer and such reduction shall be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the ceding insurer, under a reinsurance contract with such assuming insurer as security for the payment of obligations thereunder, if such security is held in the United States subject to withdrawal solely by, and under the exclusive control of, the ceding insurer; or, in the case of a trust, held in a qualified United States financial institution, as defined in paragraph (2) of subsection (c) of this Code section. This security may be in the form of:

(1) Cash;

(2) Securities listed by the Securities Valuation Office of the National Association of Insurance Commissioners, including those deemed exempt from filing as defined by the Purposes and Procedures Manual of the Securities Validation Office, and qualifying as admitted assets;

(3) Clean, irrevocable, unconditional letters of credit, issued or confirmed by a qualified United States institution, as defined in paragraph (1) of subsection (c) of this Code section, no later than December 31 of the year for which filing is being made, and in the possession of, or in the trust for, the ceding insurer on or before the filing date of its annual statement. Letters of credit meeting applicable standards of issuer acceptability as of the dates of their issuance or confirmation shall, notwithstanding the issuing or confirming institution's subsequent failure to meet applicable standards of issuer acceptability, continue to be acceptable as security until their expiration, extension, renewal, modification, or amendment, whichever first occurs; or

(4) Any other form of security acceptable to the Commissioner.

(c)(1) For purposes of paragraph (3) of subsection (b) of this Code section, "qualified United States financial institution" means an institution that:

(A) Is organized or, in the case of a United States office of a foreign banking organization, licensed under the laws of the United States or any state thereof;

(B) Is regulated, supervised, and examined by the United States federal or state authorities having regulatory authority over banks and trust companies; and

(C) Has been determined by either the Commissioner or the Securities Valuation Office of the National Association of Insurance Commissioners to meet such standards of financial condition and standing as are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the Commissioner.

(2) A "qualified United States financial institution" means, for the purposes of those provisions of this Code section specifying those institutions that are eligible to act as a fiduciary of a trust, an institution that:

(A) Is organized or, in the case of a United States branch or agency office of a foreign banking organization, licensed under the laws of the United States or any state thereof and has been granted authority to operate with fiduciary powers; and

(B) Is regulated, supervised, and examined by federal or state authorities having regulatory authority over banks and trust companies. (Code 1933, § 56-413, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1980, p. 1108, § 1; Ga. L. 1990, p. 1275, § 4; Ga. L. 1991, p. 1424, § 3; Ga. L. 1995, p. 1165, § 7; Ga. L. 1996, p. 705, § 2; Ga. L. 2012, p. 1117, § 5/SB 385.)

The 2012 amendment, effective July 1, 2012, rewrote this Code section.

RESEARCH REFERENCES

Am. Jur. Pleading and Practice Forms. — 14B Am. Jur. Pleading and Practice Forms, Insurance, § 615.

33-7-15. Cooperation by insured with insurer in connection with defense of action or threatened action under policy.

JUDICIAL DECISIONS

Applicability.

Because O.C.G.A. § 33-7-15(c) was limited to motor vehicle liability insurance and had no effect on the notice received by an insurance company in an action concerning a general liability policy. Holbrook-Myers Co. v. Transp. Ins. Co., 354 F. Supp. 2d 1349 (N.D. Ga. Jan. 7, 2005).

Third party notice.

Unfiled, unstamped, and unverified copy of complaint that counsel for motorist and passenger sent to insurance company was not a summons "or other process" pursuant to O.C.G.A. § 33-7-15(c) sufficient to inform the insurance company of a third party action involving its insured, and thus, did not trigger the insurance company's duties to defend or pay. Peachtree Cas. Ins. Co. v. Bhalock, 252 Ga. App. 328, 556 S.E.2d 218 (2001).

When an injured party sued the insurer of a motorist against whom the injured party obtained a judgment, both to collect on the judgment and to assert a claim, as assignee of the motorist, for bad faith failure to settle, the insurer was not entitled to summary judgment because, even though the motorist did not provide the insurer with notice of the claim, the injured party provided the insurer with sufficient notice, under O.C.G.A. § 33-7-15(c), when it provided the insurer a copy of the complaint, with a court clerk's notation of the case number and the date on which the complaint was filed, and the insurer did not show that the injured party's failure to provide the insurer with a copy of the summons deprived it of the ability to timely and adequately investigate the claim. Canal Indem. Co. v. Greene, 265 Ga. App. 67, 593 S.E.2d 41 (2003).

Notice requirement not negated. — This section does not negate the requirement that an in personam judgment must be obtained against the insured tortfeasor before the insurer will be obligated to pay it. Southeastern Sec. Ins. Co. v. Lowe, 242 Ga. App. 535, 530 S.E.2d 231 (2000).

Attorney's fees.

Trial court did not err in denying an insured's motion for attorney fees under O.C.G.A. § 33-7-15(b.1) as the insured could have requested attorney fees under O.C.G.A. § 33-7-15(b.1) at the time the insured sought O.C.G.A. § 13-6-11 attorney fees below; thus, the request for O.C.G.A. § 33-7-15(b.1) fees was barred by the doctrine of res judicata. Ponse v. Atlanta Cas. Co., 270 Ga. App. 122, 605 S.E.2d 826 (2004).

Failure to cooperate. — When an injured party sued the insurer of the motorist against whom the injured party obtained a judgment, the insurer was not entitled to summary judgment based on its argument, under O.C.G.A. § 33-7-15(a), that it was relieved of liability due to its insured's failure to cooperate with it because there were genuine issues of material fact as to whether the insured failed to cooperate. Canal Indem. Co. v. Greene, 265 Ga. App. 67, 593 S.E.2d 41 (2003).

Trial court did not err in entering judgment in favor of an insurer in a couple's action seeking satisfaction of a judgment they recovered against an insured in a personal injury suit because the evidence supported a finding that the insurer reasonably requested the insured's cooperation, that the insured willfully and intentionally failed to cooperate, that the insured's failure to cooperate was prejudicial to the insurer, and that the insured's justification for failing to respond was insufficient. Vaughan v. ACCC Ins. Co., No. A11A2117, 2012 Ga. App. LEXIS 277 (Mar. 12, 2012).

Cited in Thomas v. Atlanta Cas. Co., 253 Ga. App. 199, 558 S.E.2d 432 (2001).

CHAPTER 8

FEES AND TAXES

33-8-1. Fees and charges generally.

The Commissioner is authorized to assess and collect in advance, and persons so assessed shall pay in advance to the Commissioner, fees and charges under this title as follows:

(1) Unless specifically provided otherwise, for each certificate of authority, original license, renewal of a certificate of authority, or renewal of a license:

(A) Agent, subagent, counselor, adjuster, or principal office of an insurance agency (new license)	$ 100.00
(B) Agent, subagent, counselor, adjuster, or principal office of an insurance agency (biennial license renewal)	100.00
(B.1) Each branch office of an insurance agency other than the principal office (new license)	20.00
(B.2) Each branch office of an insurance agency other than the principal office (biennial license renewal)	20.00
(C) Agent certificate of authority for subagent	5.00
(D) Automobile self-insurance	100.00
(E) Captive insurance company:	
Original license or certificate	600.00
Renewal license or certificate	500.00
(F) Continuing care provider	75.00
(G) Duplicate certificate of authority, license, or permit	25.00

(H) Farmers mutual fire insurance company:	
Original license or certificate	500.00
Renewal license or certificate	25.00
(I) Fraternal benefit society:	
Original license or certificate	600.00
Renewal license or certificate	500.00
(I.1) Health care corporations:	
Original license or certificate	600.00
Renewal license or certificate	500.00
(J) Health maintenance organization:	
Original license or certificate	600.00
Renewal license or certificate	500.00
(K) Insurer certificate of authority for agent	10.00
(L) Life, accident, and sickness insurance company:	
Original license or certificate	600.00
Renewal license or certificate	500.00
(M) Managing general agent:	
Original license or certificate	600.00
Renewal license or certificate	500.00
(N) Multiple employer self-insurance plan	400.00
(O) Premium finance company (full power)	500.00
(P) Premium finance company (limited power)	300.00
(Q) Reserved	
(R) Prepaid legal services plans	500.00
(S) Private review agents:	
Original license or certificate	1,000.00
Renewal license or certificate	500.00
(T) Property and casualty insurance company:	
Original license or certificate	600.00
Renewal license or certificate	500.00

(U) Nonprofit organizations (medical service or hospital service corporation):	
Original license or certificate	600.00
Renewal license or certificate	500.00
(V) Rating or advisory organization	100.00
(W) Reinsurance intermediary	50.00
(X) Surplus lines broker	600.00
(Y) Third-party administrators:	
Original license or certificate	500.00
Renewal license or certificate	400.00
(Z) Title insurance company:	
Original license or certificate	600.00
Renewal license or certificate	500.00
(AA) Utilization review agent	200.00
(BB) Each vending machine licensed under Chapter 23 of this title	25.00
(CC) Workers' compensation group self-insurance fund:	
Original license or certificate	600.00
Renewal license or certificate	500.00
(2) Bond or security deposits:	
(A) Not over $5,000.00	4.00
(B) Not over $10,000.00	8.00
(C) Not over $25,000.00	15.00
(D) Not over $50,000.00	25.00
(E) Over $50,000.00 but less than $100,000.00	40.00
(F) $100,000.00 or more	50.00
(3) Examination fee for agent's, subagent's, counselor's, or adjuster's license	25.00
(4) Application fee for agent's, subagent's, adjuster's, or counselor's license	15.00
(5) Status letter for agent, subagent, counselor, or adjuster	10.00

(6) For the following filings:

(A) Bylaws amendments	25.00
(B) Certification of annual statement	10.00
(C) Certification of examination report	10.00
(D) Certification of other documents	5.00
(E) Charter amendments	25.00
(F) Education course provider (original filing)	100.00
(G) Education course provider (renewal filing)	50.00
(H) Education course or program	10.00
(I) Education course instructor	10.00
(J) Financial statement	50.00
(K) Form A	5,000.00
(L) Form A exemption	1,000.00
(M) Form B	500.00
(N) Form B exemption	100.00
(O) Individual risk rate or form	10.00
(P) Insurance policy form	25.00
(Q) Insurance rate filing	75.00
(R) Listing of licensed agents, subagents, counselors, or adjusters	1,000.00
(S) Listing of insurer's certificates of authority filed for agents	5.00
(T) Listing of agent's certificates of authority filed for subagents	5.00
(U) List of licensees or permit or certificate holders other than agents, subagents, counselors, or adjusters	40.00
(V) License, permit, or certificate of authority amendment	25.00
(W) Late fee for filings	15.00
(X) Registration of risk retention groups	100.00
(Y) Registration of purchasing groups	100.00
(Z) Filing of other documents	50.00

(AA) Amendment of filings 25.00

Provided, however, that the Commissioner, in his or her discretion, may exempt from such fee change of address filings done off line by agents, subagents, counselors, and adjusters.

(AA.1) Change of address filings done on line by agents, subagents, counselors, and adjusters ..... No charge

(BB) Service of process 15.00

(7) For refiling of corrected documents under this Code section, provided that fees were paid with original filing ..... No charge

(Code 1933, § 56-1301, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1973, p. 499, § 3; Ga. L. 1976, p. 535, § 3; Ga. L. 1983, p. 729, § 1; Ga. L. 1985, p. 1399, § 4; Ga. L. 1987, p. 3, § 33; Ga. L. 1988, p. 1519, §§ 2, 3; Ga. L. 1992, p. 2725, § 11; Ga. L. 1994, p. 858, § 1; Ga. L. 1995, p. 745, §§ 2.2, 2.3; Ga. L. 1997, p. 1296, § 2; Ga. L. 2000, p. 882, § 3; Ga. L. 2006, p. 652, § 6/HB 1257; Ga. L. 2011, p. 623, § 1/SB 251.)

The 2006 amendment, effective July 1, 2006, in paragraph (6), inserted the proviso following subparagraph (6)(AA) and added subparagraph (6)(AA.1).

The 2011 amendment, effective May 12, 2011, in subparagraphs (1)(A) and (1)(B), substituted "100.00" for "50.00"; in subparagraphs (1)(B) and (1)(B.2), inserted "biennial"; in subparagraphs (1)(B.1) and (1)(B.2), substituted "20.00" for "10.00"; and, in subparagraph (1)(X), substituted "600.00" for "300.00".

33-8-4. Amount and method of computing tax on insurance premiums generally; exclusion of annuity considerations.

(a) All foreign, alien, and domestic insurance companies doing business in this state shall pay a tax of 2 1/4 percent upon the gross direct premiums received by them on and after July 1, 1955. The tax shall be levied upon persons, property, or risks in Georgia, from January 1 to December 31, both inclusive, of each year without regard to business ceded to or assumed from other companies. The tax shall be imposed upon gross premiums received from direct writings without any deductions allowed for premium abatements of any kind or character or for reinsurance or for cash surrender values paid, or for losses or expenses of any kind; provided, however, deductions shall be allowed for premiums returned on change of rate or canceled policies; provided, further, that deductions may be permitted for return premiums or assessments, including all policy dividends, refunds, or other similar returns paid or credited to policyholders and not reapplied as premium for additional or

extended life insurance. The term "gross direct premiums" shall not include annuity considerations.

(b) For purposes of this chapter, annuity considerations received by nonprofit corporations licensed to do business in this state issuing annuities to fund retirement benefits for teachers and staff personnel of private secondary schools and colleges and universities shall not be considered gross direct premium.

(c) Insurers shall be exempt from otherwise applicable state premium taxes as provided for in subsection (a) of this Code section on premiums paid by Georgia residents for high deductible health plans as defined by Section 223 of the Internal Revenue Code. (Code 1933, § 56-1303, enacted by Ga. L. 1960, p. 289, § 1; Code 1933, § 56-1312, enacted by Ga. L. 1973, p. 499, § 4; Ga. L. 1976, p. 1080, § 2; Ga. L. 1979, p. 850, § 2; Ga. L. 2008, p. 292, § 1/HB 977; Ga. L. 2009, p. 652, § 1/HB 410.)

The 2008 amendment, effective January 1, 2009, added subsection (c). See the editor's note for applicability.

The 2009 amendment, effective May 4, 2009, substituted "as defined by" for "sold or maintained in connection with a health savings account under the applicable provisions of" near the end of subsection (c). See the editor's note for applicability.

Editor's notes. — Ga. L. 2008, p. 299, § 6(a), not codified by the General Assembly, provides in part that the 2008 amendment is applicable to all taxable years beginning on or after January 1, 2009.

Ga. L. 2009, p. 652, § 6(a), not codified by the General Assembly, provides, in part, that the amendment to this Code section "shall be applicable to all taxable years beginning on or after January 1, 2009".

Law reviews. — For article, "Revenue and Taxation: Amend Titles 48, 2, 28, 33, 36, 46, and 50 of the Official Code of Georgia Annotated, Relating Respectively to Revenue and Taxation, Agriculture, the General Assembly, Insurance, Local Government, Public Utilities, and State Government," see 28 Ga. St. U. L. Rev. 217 (2011).

33-8-4.1. State insurance premiums tax credits for insurance companies located in certain counties designated as less developed areas; authority of commissioner of community affairs and Commissioner of Insurance.

(a) As used in this Code section, the term:

(1) "Business enterprise" means any insurance company or the headquarters of any insurance company required to pay the tax under Code Section 33-8-4.

(2) "Existing business enterprise" means any insurance company or the headquarters of any insurance company required to pay the tax under Code Section 33-8-4 which has operated for the immediately preceding three years a facility in this state.

(b)(1) Not later than December 31 of each year, using the most current data available from the Department of Labor and the United

States Department of Commerce, the commissioner of community affairs shall rank and designate as less developed areas all 159 counties in this state using a combination of the following equally weighted factors:

(A) Highest unemployment rate for the most recent 36 month period;

(B) Lowest per capita income for the most recent 36 month period; and

(C) Highest percentage of residents whose incomes are below the poverty level according to the most recent data available.

(2) Counties ranked and designated as the first through seventy-first least developed counties shall be classified as tier 1, counties ranked and designated as the seventy-second through one hundred sixth least developed counties shall be classified as tier 2, counties ranked and designated as the one hundred seventh through one hundred forty-first least developed counties shall be classified as tier 3, and counties ranked and designated as the one hundred forty-second through one hundred fifty-ninth least developed counties shall be classified as tier 4.

(c) The commissioner of community affairs shall be authorized to include in the tier 2 designation provided for in subsection (b) of this Code section any tier 3 county which, in the opinion of the commissioner of community affairs, undergoes a sudden and severe period of economic distress caused by the closing of one or more business enterprises located in such county. No designation made pursuant to this subsection shall operate to displace or remove any other county previously designated as a tier 2 county.

(d) The commissioner of community affairs shall be authorized to include in the tier 1 designation provided for in subsection (b) of this Code section any tier 2 county which, in the opinion of the commissioner of community affairs, undergoes a sudden and severe period of economic distress caused by the closing of one or more business enterprises located in such county. No designation made pursuant to this subsection shall operate to displace or remove any other county previously designated as a tier 1 county.

(e) For business enterprises which plan a significant expansion in their labor forces, the commissioner of community affairs shall prescribe redesignation procedures to ensure that the business enterprises can claim credits in future years without regard to whether or not a particular county is reclassified in a different tier.

(f)(1) Business enterprises in counties designated by the commissioner of community affairs as tier 1 counties shall be allowed a job

tax credit for taxes imposed under Code Section 33-8-4 equal to $3,500.00 annually per eligible new full-time employee job for five years beginning with years two through six after the creation of such job. Business enterprises in counties designated by the commissioner of community affairs as tier 2 counties shall be allowed a job tax credit for taxes imposed under Code Section 33-8-4 equal to $2,500.00 annually, business enterprises in counties designated by the commissioner of community affairs as tier 3 counties shall be allowed a job tax credit for taxes imposed under Code Section 33-8-4 equal to $1,250.00 annually, and business enterprises in counties designated by the commissioner of community affairs as tier 4 counties shall be allowed a job tax credit for taxes imposed under Code Section 33-8-4 equal to $750.00 annually for each new full-time employee job for five years beginning with years two through six after the creation of the job. The number of new full-time jobs shall be determined by comparing the monthly average number of full-time employees subject to Georgia income tax withholding for the calendar year with the corresponding period of the prior calendar year. In tier 1 counties, those business enterprises that increase employment by five or more shall be eligible for the credit. In tier 2 counties, only those business enterprises that increase employment by ten or more shall be eligible for the credit. In tier 3 counties, only those business enterprises that increase employment by 15 or more shall be eligible for the credit. In tier 4 counties, only those business enterprises that increase employment by 25 or more shall be eligible for the credit. The average wage of the new jobs created must be above the average wage of the county that has the lowest average wage of any county in the state to qualify as reported in the most recently available annual issue of the Georgia Employment and Wages Averages Report of the Department of Labor. To qualify for a credit under this paragraph, the employer must make health insurance coverage available to the employee filling the new full-time job; provided, however, that nothing in this paragraph shall be construed to require the employer to pay for all or any part of health insurance coverage for such an employee in order to claim the credit provided for in this paragraph if such employer does not pay for all or any part of health insurance coverage for other employees. Credit shall not be allowed during a year if the net employment increase falls below the number required in such tier. Any credit received for years prior to the year in which the net employment increase falls below the number required in such tier shall not be affected. The Commissioner of Insurance shall adjust the credit allowed each year for net new employment fluctuations above the minimum level of the number required in such tier.

(2) Existing business enterprises as defined under paragraph (2) of subsection (a) of this Code section shall be allowed an additional tax

credit for taxes imposed under Code Section 33-8-4 equal to $500.00 per eligible new full-time employee job for one year after the creation of such job. The additional credit shall be claimed in year two after the creation of such job. The number of new full-time jobs shall be determined by comparing the monthly average number of full-time employees subject to Georgia income tax withholding for the calendar year with the corresponding period of the prior calendar year. In tier 1 counties, those existing business enterprises that increase employment by five or more shall be eligible for the credit. In tier 2 counties, only those existing business enterprises that increase employment by ten or more shall be eligible for the credit. In tier 3 counties, only those existing business enterprises that increase employment by 15 or more shall be eligible for the credit. In tier 4 counties, only those existing business enterprises that increase employment by 25 or more shall be eligible for the credit. The average wage of the new jobs created must be above the average wage of the county that has the lowest average wage of any county in the state to qualify as reported in the most recently available annual issue of the Georgia Employment and Wages Averages Report of the Department of Labor. To qualify for a credit under this paragraph, the employer must make health insurance coverage available to the employee filling the new full-time job; provided, however, that nothing in this paragraph shall be construed to require the employer to pay for all or any part of health insurance coverage for such an employee in order to claim the credit provided for in this paragraph if such employer does not pay for all or any part of health insurance coverage for other employees. Credit shall not be allowed during a year if the net employment increase falls below the number required in such tier. Any credit received for years prior to the year in which the net employment increase falls below the number required in such tier shall not be affected. The Commissioner of Insurance shall adjust the credit allowed each year for net new employment fluctuations above the minimum level of the number required in such tier. This paragraph shall apply only to new eligible full-time jobs created on or after January 1, 2009, and prior to January 1, 2014.

(g) Tax credits for five years for the taxes imposed under Code Section 33-8-4 shall be awarded for additional new full-time jobs created by business enterprises qualified under subsection (b), (c), or (d) of this Code section. Additional new full-time jobs shall be determined by subtracting the highest total employment of the business enterprise during years two through six, or whatever portion of years two through six which has been completed, from the total increased employment. The Commissioner of Insurance shall adjust the credit allowed in the event of employment fluctuations during the additional five years of credit.

(h) The sale, merger, acquisition, or bankruptcy of any business enterprise shall not create new eligibility in any succeeding business entity, but any unused job tax credit may be transferred and continued by any transferee of the business enterprise. The commissioner of community affairs shall determine whether or not qualifying net increases or decreases have occurred and may require reports, promulgate regulations, and hold hearings as needed for substantiation and qualification.

(i)(1) Except as provided in paragraph (2) of this subsection, any credit claimed under this Code section but not used in that calendar year may be carried forward for ten years from the close of the calendar year in which the qualified jobs were established, but in tiers 3 and 4 the credit established by this Code section taken in any one calendar year shall be limited to an amount not greater than 50 percent of the taxpayer's tax liability under Code Section 33-8-4 which is attributable to operations in this state for that calendar year. In tier 1 and 2 counties, the credit allowed under this Code section against taxes imposed under Code Section 33-8-4 in any calendar year shall be limited to an amount not greater than 100 percent of the taxpayer's tax liability under Code Section 33-8-4 attributable to operations in this state for such calendar year.

(2) The additional credit claimed by an existing business enterprise pursuant to the provisions of paragraph (2) of subsection (f) of this Code section must be applied against taxes imposed for the calendar year in which such credit is available and may not be carried forward to any subsequent calendar year.

(j) The Commissioner of Insurance may require such reports, promulgate such regulations, and gather such relevant data necessary and advisable for the evaluation of the job tax credits established by this Code section. (Code 1981, § 33-8-4.1, enacted by Ga. L. 2008, p. 874, § 7/HB 1246.)

Effective date. — This Code section became effective January 1, 2009.

33-8-4.2. Assignment, carryover and liability regarding tax credits.

(a) As used in this Code section, the term "affiliated entity" means:

(1) A corporation that is a member of the taxpayer's "affiliated group" within the meaning of Section 1504(a) of the Internal Revenue Code and which corporation has a tax liability under Code Section 33-8-4; or

(2) An entity affiliated with a corporation, business, partnership, or limited liability company taxpayer, which entity has a tax liability under Code Section 33-8-4 and which entity:

(A) Owns or leases the land on which a project is constructed;

(B) Provides capital for construction of the project; and

(C) Is the grantor or owner under a management agreement with a managing company of the project.

(b) In lieu of claiming any tax credit under Code Section 33-8-4.1 for which a taxpayer otherwise is eligible for the calendar year (such eligibility being determined for this purpose without regard to any limitation imposed by reason of the taxpayer's precredit tax liability under Code Section 33-8-4), the taxpayer may elect to assign such credit in whole or in part to one or more affiliated entities for such calendar year by attaching a statement to the taxpayer's return for the calendar year; provided, however, that no carryover attributable to the unused portion of any previously claimed or assigned credit may be assigned or reassigned, except as provided in subsection (d) of this Code section. Such election must be made on or before the due date for filing the applicable tax return under Code Section 33-8-4, including any extensions which have been granted. In the case of any credit that must be claimed in installments in more than one calendar year, the election under this subsection may be made on an annual basis with respect to each such installment, provided that the taxpayer shall notify the Commissioner of Insurance with respect to the assignment of each such installment by filing a separate copy of the election statement for such installment no later than the due date for filing the applicable tax return under Code Section 33-8-4, including any extensions which have been granted. Once made, an election under this subsection shall be irrevocable.

(c) The recipient of a tax credit assigned under subsection (b) of this Code section shall attach a statement to its tax return under Code Section 33-8-4 identifying the assignor of the tax credit, in addition to providing any other information required to be provided by a claimant of the assigned tax credit.

(d) If the assignor and the recipient of a tax credit assigned under subsection (b) of this Code section cease to be affiliated entities, any carryover attributable to the unused portion of such credit shall be transferred back to the assignor of the credit. Such assignor shall be permitted to use any such carryover itself and also shall be permitted to assign such carryover to one or more affiliated entities, as if such carryover were a tax credit under Code Section 33-8-4.1 for which the assignor became eligible in the calendar year in which the carryover was transferred back to the assignor.

(e) The assignor and recipient of a tax credit assigned under subsection (b) of this Code section shall be jointly and severally liable for any tax under Code Section 33-8-4 (plus interest and penalties, if any) attributable to the disallowance or recapture of the assigned credit. (Code 1981, § 33-8-4.2, enacted by Ga. L. 2008, p. 874, § 8/HB 1246.)

Effective date. — This Code section became effective January 1, 2009.

33-8-8.1. County and municipal corporation taxes on life insurance companies.

(a) As used in this Code section, the term "life insurance company" means a company which is authorized to transact only the class of insurance designated in Code Section 33-3-5 as class (1).

(a.1) (Repealed effective January 1, 2015.) Insurers shall be exempt from otherwise applicable local premium taxes as provided for in subsection (b) of this Code section on premiums paid by Georgia residents for high deductible health plans as defined by Section 223 of the Internal Revenue Code. This subsection shall stand repealed in its entirety on January 1, 2015.

(b) Life insurance companies are subject to county and municipal corporation taxes levied as follows:

(1) There is imposed a county tax for county purposes on each life insurance company doing business within the state, which tax shall be based solely upon gross direct premiums, as defined in Code Section 33-8-4, which are received during the preceding calendar year from policies insuring persons residing within the unincorporated area of the counties pursuant to the provisions of this Code section. The rate of such tax shall be 1 percent of such premiums, except that such tax shall not apply to the gross direct premiums of an insurance company which qualifies, pursuant to Code Section 33-8-5, for the reduction to one-half of 1 percent of the state tax imposed by Code Section 33-8-4. The tax imposed by this Code section shall not apply to annuity considerations; and

(2) Municipal corporations whose ordinances have been filed with the Commissioner are authorized to impose a tax on each life insurance company doing business within the state, which tax shall be based solely upon the gross direct premiums, as defined in Code Section 33-8-4, which are received during the preceding calendar year from policies insuring persons residing within the corporate limits of the municipal corporation pursuant to the provisions of this Code section; provided, however, that the rate of the tax may not exceed 1 percent of the premiums. The tax imposed shall not apply to annuity considerations.

(c)(1) On March 1, 1984, and on that date in each subsequent year, each life insurance company shall file a certified return on a form prescribed by the Commissioner showing gross direct premiums received during the preceding calendar year that will appear in the company's certified annual statement.

(2) Reserved.

(3) On or before August 1, 1988, and on the same date in each subsequent year, the Commissioner shall collect taxes imposed pursuant to subsection (b) of this Code section on behalf of counties and municipal corporations whose ordinances have been filed with the Commissioner. The tax collected for each year shall be based upon gross direct premiums written during the preceding calendar year. Penalty and interest as prescribed in subsection (d) of Code Section 33-8-6 shall be imposed for late payment, underpayment, or nonpayment of such taxes.

(d) Taxes imposed by subsection (b) of this Code section shall be allocated and distributed to counties and municipal corporations as follows:

(1) A portion of the total amount of life insurance premiums taxable by the state, exclusive of premiums collected by companies which qualify for the reduction to one-half of 1 percent of the state tax, shall be allocated to counties based upon the ratio that the total population of all unincorporated areas in the state bears to the total population in the state. The amount of the tax base so allocated to counties shall be taxed at the rate levied for county purposes. The tax shall be distributed to each county governing authority by the Commissioner based upon a fraction, the numerator of which is the population of the unincorporated area of that county and the denominator of which is the population of all unincorporated areas of the state; and

(2) A portion of the total amount of life insurance premiums taxable by the state shall be allocated to all municipal corporations based upon the ratio that the total population of all municipal corporations bears to the total state population. The amount of the tax base so allocated to municipalities shall be distributed to each municipal corporation based upon the fraction, the numerator of which is the population of that municipal corporation and the denominator of which is the population of all municipal corporations in the state. The amount of the tax base so distributed to each municipality shall be taxed at the rate levied by that municipality; and taxes levied by each municipal corporation shall be distributed based upon the tax rate levied by each such municipal corporation.

(e) On or before January 1 of the first year that the tax is levied, each municipal corporation levying the tax shall file with the Commissioner

a certified copy of the pertinent parts of all ordinances and amendments thereto which impose the tax, and such filing shall be a condition to the validity and enforceability of such an ordinance. On or before February 1 of each year the Commissioner shall furnish a list of all municipal corporations levying the tax for that year to each life insurance company in the state.

(f) Life insurance companies may deduct from premium taxes otherwise payable to this state under Code Section 33-8-4, in addition to all credits and abatements allowed by law, the taxes imposed pursuant to subsection (b) of this Code section and paid to the Commissioner on behalf of any county and municipal corporation during the preceding calendar year.

(g) On or before October 15, 1988, and on the same date in each subsequent year, the Commissioner shall distribute the taxes imposed by counties and municipal corporations which are actually remitted to and collected by the Commissioner. On or before October 15, 1988, and on the same date in each subsequent year, the Commissioner shall distribute any delinquent taxes actually collected by the Commissioner for a previous year, exclusive of any interest or penalty on such delinquent taxes, which delinquent taxes have not previously been distributed.

(h) Amounts collected by the Commissioner under or due under former Code Section 33-8-8.1 shall be collected and disbursed as provided in former Code Section 33-8-8.1.

(i) For purposes of this Code section, population shall be measured by the United States decennial census of 1990 or any future such census plus any corrections or revisions contained in official statements by the United States Bureau of the Census made prior to the first day of September immediately preceding the distribution of the proceeds of such taxes by the Commissioner and any additional official census data received by the Commissioner from the United States Bureau of the Census or its successor agency pertaining to any newly incorporated municipality. Such corrections, revisions, or additional data shall be certified to the Commissioner by the Office of Planning and Budget on or before August 31 of each year. (Code 1933, § 56-1310.1, enacted by Ga. L. 1981, p. 380, § 2; Ga. L. 1983, p. 1595, § 2; Ga. L. 1984, p. 22, § 33; Ga. L. 1984, p. 1284, § 2; Ga. L. 1988, p. 13, § 33; Ga. L. 1988, p. 1581, § 1; Ga. L. 1994, p. 528, § 1; Ga. L. 2009, p. 652, § 2/HB 410.)

The 2009 amendment, effective May 4, 2009, added subsection (a.1). See the editor's note for applicability.

Editor's notes. — Ga. L. 2009, p. 652, § 6(b), not codified by the General Assembly, provides, in part, that the amendment to this Code section "shall be applicable to all taxable years beginning on or after January 1, 2010".

U.S. Code. — Section 223 of the Inter-

nal Revenue Code, referred to in subsection (a.1) of this Code section, is codified at 26 U.S.C. § 223.

Law reviews. — For article, "Revenue and Taxation: Amend Titles 48, 2, 28, 33, 36, 46, and 50 of the Official Code of Georgia Annotated, Relating Respectively to Revenue and Taxation, Agriculture, the General Assembly, Insurance, Local Government, Public Utilities, and State Government," see 28 Ga. St. U. L. Rev. 217 (2011).

33-8-8.2. County and municipal corporation taxes on other than life insurance companies.

(a) Counties and municipal corporations are authorized to levy tax at a rate not to exceed 2.5 percent upon the gross direct premiums of all foreign, alien, and domestic insurance companies doing business in this state other than life insurance companies. The tax shall be in addition to the taxes levied by Code Section 33-8-4, and it may be levied upon the gross direct premiums received by such companies during the preceding calendar year. The tax shall be levied upon premiums derived from policies insuring persons, property, or risks in Georgia from January 1 to December 31, both inclusive, of each year without regard to business ceded to or assumed from other companies. The tax shall be imposed upon gross premiums received during the preceding calendar year from direct writing without any deductions allowed from premium abatement of any kind or character or for reinsurance or for losses or expenses of any kind; provided, however, deductions shall be allowed for premiums returned or change of rate or canceled policies; provided, further, that deductions shall be permitted for returned premiums or assessments, including all policy dividends, refunds, or other similar returns paid or credited to policyholders.

(a.1) (Repealed effective January 1, 2015. See note.) Insurers shall be exempt from otherwise applicable local premium taxes as provided for in subsection (a) of this Code section on premiums paid by Georgia residents for high deductible health plans as defined by Section 223 of the Internal Revenue Code.

(b) The taxes provided in this Code section are county and municipal taxes and shall be levied for county and municipal purposes and shall be collected and distributed as follows:

(1) On or before January 1 of the first year that the tax is levied, each county and municipal corporation levying the tax shall file with the Commissioner a certified copy of the pertinent parts of all ordinances and resolutions and amendments thereto which impose the tax, and such filing shall be a condition to the validity and enforceability of such an ordinance or resolution;

(2) On or before February 1 of each year, the Commissioner shall furnish to each insurance company a list of all counties and municipal corporations where the tax as authorized by this Code section has

been imposed for the then current year together with the applicable tax rate levied by each such county and municipal corporation and the population percentages by which the taxes are to be allocated to each such county and municipal corporation as provided in this Code section;

(3)(A) On March 1, 1984, and on the same date in each subsequent year, each insurance company upon which a tax is imposed by subsection (b) of this Code section shall file a certified return on a form prescribed by the Commissioner showing gross direct premiums received during the preceding calendar year that will appear in the company's certified annual statement.

(B) Reserved.

(C) On or before August 1, 1988, and on the same date in each subsequent year, the Commissioner shall collect taxes imposed pursuant to this Code section on behalf of counties and municipal corporations whose ordinances have been filed with the Commissioner. The premiums tax collected for each year shall be based upon gross direct premiums written during the preceding calendar year. Penalty and interest as prescribed in subsection (d) of Code Section 33-8-6 shall be imposed for late payment, underpayment, or nonpayment of such taxes;

(4) The total amount of premiums taxable by the state on insurance companies as defined in this Code section shall be allocated to each county unincorporated area and each municipal corporation based upon a fraction, the numerator of which is the population of the unincorporated area or municipal corporation and the denominator of which is the total population of the state. Tax rates levied by each county shall be applied to the premiums allocated to its unincorporated area, and tax rates levied by each municipal corporation shall be applied to the premiums allocated to it; and

(5) On or before October 15, 1988, and on the same date in each subsequent year, the Commissioner shall distribute the taxes imposed by counties and municipal corporations which are actually remitted to and collected by the Commissioner. On or before October 15, 1988, and on the same date in each subsequent year, the Commissioner shall distribute any delinquent taxes actually collected by the Commissioner for a previous year, exclusive of any interest or penalty on such delinquent taxes, which delinquent taxes have not previously been distributed.

(c) For purposes of this Code section, population shall be measured by the United States decennial census of 1990 or any future such census plus any corrections or revisions contained in official statements by the United States Bureau of the Census made prior to the first day of

September immediately preceding the distribution of the proceeds of such taxes by the Commissioner and any additional official census data received by the Commissioner from the United States Bureau of the Census or its successor agency pertaining to any newly incorporated municipality. Such corrections, revisions, or additional data shall be certified to the Commissioner by the Office of Planning and Budget on or before August 31 of each year.

(d) Any county or municipal corporation which, on January 1, 1983, levied a tax on all premiums of insurance companies, other than life insurance companies, at a rate in excess of 2.5 percent may continue to levy the tax at a rate in excess of 2.5 percent, provided that the rate of such tax shall not exceed the rate which was in effect in such county or municipal corporation on January 1, 1983, reduced annually beginning January 1, 1984, by one-third of the difference between such January 1, 1983, rate and 2.5 percent, so that the rate levied on January 1, 1986, shall not exceed 2.5 percent.

(e) It shall be in contravention of public policy for a county or a municipal corporation that levies taxes for county or municipal purposes on foreign, alien, and domestic insurance companies doing business in this state, as provided in subsection (a) of this Code section, to impose additional taxes or any other fees of any kind for services provided by such county or municipal corporation to such insurance companies for accidents involving motor vehicles except for the following:

(1) Where the coverage for such services is expressly provided by an insurance company to the insured and the services are lawfully billed to the insured;

(2) Where emergency medical services are provided to the insured by the county or municipal corporation, whenever the insured's medical insurance covers the services provided and the insured assigns the right to collect to the service provider; or

(3) Where other services are provided to the insured by the county or municipal corporation which are expressly authorized by state or federal law to be billed directly to an insurance company. (Code 1981, § 33-8-8.2, enacted by Ga. L. 1983, p. 1595, § 3; Ga. L. 1984, p. 22, § 33; Ga. L. 1984, p. 1284, § 2; Ga. L. 1985, p. 149, § 33; Ga. L. 1988, p. 1581, § 1; Ga. L. 1994, p. 528, § 2; Ga. L. 2008, p. 292, § 2/HB 977; Ga. L. 2008, p. 490, § 1/SB 348; Ga. L. 2009, p. 652, § 3/HB 410.)

The 2008 amendments. — The first 2008 amendment, effective May 7, 2008, and expiring January 1, 2015, added subsection (a.1). The second 2008 amendment, effective May 12, 2008, added subsection (e).

The 2009 amendment, effective May 4, 2009, substituted "as defined by" for "sold or maintained in connection with a health savings account under the applicable provisions of" near the end of subsection (a.1). See the editor's note for applicability.

Editor's notes. — Ga. L. 2008, p. 292,

§ 6(b), not codified by the General Assembly, provides: "Section 2 of this Act shall expire on January 1, 2015, unless the General Assembly acts to extend these provisions."

Ga. L. 2009, p. 652, § 6(a), not codified by the General Assembly, provides, in part, that the amendment to this Code section "shall be applicable to all taxable years beginning on or after January 1, 2009".

Law reviews. — For article, "Revenue and Taxation: Amend Titles 48, 2, 28, 33, 36, 46, and 50 of the Official Code of Georgia Annotated, Relating Respectively to Revenue and Taxation, Agriculture, the General Assembly, Insurance, Local Government, Public Utilities, and State Government," see 28 Ga. St. U. L. Rev. 217 (2011).

CHAPTER 9

REGULATION OF RATES, UNDERWRITING RULES, AND RELATED ORGANIZATIONS

Sec.

33-9-4. Standards applicable to making and use of rates.

The following standards shall apply to the making and use of rates pertaining to all classes of insurance to which this chapter is applicable:

(1) Rates shall not be excessive or inadequate, as defined in this Code section, nor shall they be unfairly discriminatory;

(2) No rate shall be held to be excessive unless such rate is unreasonably high for the insurance provided and a reasonable degree of competition does not exist in the area with respect to the classification to which such rate is applicable; provided, however, with respect to rate filings involving an increase in rates, no rate for

personal private passenger motor vehicle insurance shall be held to be excessive unless such rate is unreasonably high for the insurance provided and a reasonable degree of competition does not exist;

(3) No rate shall be held inadequate unless it is unreasonably low for the insurance provided and continued use of it would endanger solvency of the insurer, or unless the use of such rate by the insurer using such rate has, or will, if continued, tend to destroy competition or create a monopoly;

(4) Consideration shall be given to the extent applicable to past and prospective loss experience within and outside this state, to conflagration and catastrophe hazards, to a reasonable margin for underwriting profit and contingencies, to past and prospective expenses both country wide and those specially applicable to this state, to the insurer's average yield from investment income, and to all other factors, including judgment factors, deemed relevant within and outside this state; and, in the case of fire insurance rates, consideration may be given to the experience of the fire insurance business during the most recent five-year period;

(5) Consideration may also be given, in the making and use of rates, to dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers;

(6) The systems of expense provisions included in the rates for use by any insurer or group of insurers may differ from those of other insurers or groups of insurers to reflect the operating methods of any such insurer or group with respect to any kind of insurance or with respect to any subdivision or combination thereof;

(7) Risks may be grouped by classifications for the establishment of rates and minimum premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans which establish standards for measuring variations in hazards or expense provisions, or both. Such standards may measure any difference among risks that have a probable effect upon losses or expenses. Classifications or modifications of classifications of risks may be established based upon size, expense, management, individual experience, location or dispersion of hazard, or any other reasonable considerations. Such classifications and modifications shall apply to all risks under the same or substantially the same circumstances or conditions; provided, however, the Commissioner shall establish the maximum amount of any such modification;

(8) Nothing contained in this Code section or elsewhere in this chapter shall be construed to repeal or modify Chapter 6 of this title, relating to unfair trade practices, and any rate, rating classification,

rating plan or schedule, or variation thereof established in violation of Chapter 6 of this title shall, in addition to the consequences stated in Chapter 6 of this title or elsewhere, be deemed violative of this Code section;

(9) No insurer shall base any standard or rating plan on vehicle insurance, in whole or in part, directly or indirectly, upon race, creed, or ethnic extraction; and

(10) No insurer shall base any standard or rating plan on vehicle insurance, in whole or in part, directly or indirectly, upon any physical disability of an insured unless the disability directly impairs the ability of the insured to drive a motor vehicle. (Code 1933, § 56-507, enacted by Ga. L. 1967, p. 684, § 1; Ga. L. 1978, p. 1423, § 1; Ga. L. 1978, p. 1936, § 1; Ga. L. 1980, p. 1011, § 2; Ga. L. 1982, p. 3, § 33; Ga. L. 1987, p. 911, § 1; Ga. L. 1988, p. 13, § 33; Ga. L. 1991, p. 1608, § 1.5; Ga. L. 1995, p. 1302, § 13; Ga. L. 2008, p. 1192, § 3/SB 276.)

The 2008 amendment, effective October 1, 2008, added "and a reasonable degree of competition does not exist" at the end of paragraph (2).

33-9-21. Maintenance and filing rates, rating plans, rating systems, or underwriting rules; examination of claim reserve practices by Commissioner.

(a) Every insurer shall maintain with the Commissioner copies of the rates, rating plans, rating systems, underwriting rules, and policy or bond forms used by it. The maintenance of rates, rating plans, rating systems, underwriting rules, and policy or bond forms with the Commissioner by a licensed rating organization of which an insurer is a member or subscriber will be sufficient compliance with this Code section for any insurer maintaining membership or subscriberships in such organization, to the extent that the insurer uses the rates, rating plans, rating systems, underwriting rules, and policy or bond forms of such organization; provided, however, the Commissioner, when he or she deems it necessary, without compliance with the rule-making procedures of this title or Chapter 13 of Title 50, the "Georgia Administrative Procedure Act":

(1) May require any domestic, foreign, and alien insurer to file the required rates, rating plans, rating systems, underwriting rules, and policy or bond forms used independent of any filing made on its behalf or as a member of a licensed rating organization, as the Commissioner shall deem to be necessary to ensure compliance with the standards of this chapter and Code Section 34-9-130 and for the best interests of the citizens of this state;

(2) Shall require, not later than July 30, 1990, each domestic, foreign, and alien insurer, writing or authorized to write workers' compensation insurance in this state, to file such insurer's own individual rate filing for premium rates to be charged for workers' compensation insurance coverage written in this state. Such premium rates shall be developed and established based upon each individual insurer's experience in the State of Georgia to the extent actuarially credible. The experience filed shall include the loss ratios, reserves, reserve development information, expenses, including commissions paid and dividends paid, investment income, pure premium data adjusted for loss development and loss trending, profits, and all other data and information used by that insurer in formulating its workers' compensation premium rates which are used in this state and any other information or data required by the Commissioner. In establishing and maintaining loss reserves, no workers' compensation insurer shall be allowed to maintain any excess loss reserve for any claim or potential claim for more than 90 days after the amount of liability for such claim or potential claim has been established, whether by final judgment, by settlement agreement, or otherwise. This limitation on the maintenance of loss reserves shall be enforced through this Code section, as well as through Code Section 33-9-23, relating to examination of insurers, and any other appropriate enforcement procedures. The Commissioner is authorized to accept such rate classifications as are reasonable and necessary for compliance with this chapter. A rate filing required by this paragraph shall be updated by the insurer at least once every two years, the initial two-year period to be calculated from July 30, 1990; and

(3) As used in paragraph (2) of this subsection, the term "excess loss reserve" means any reserve amount in excess of the reserve required by law.

(b) Any domestic, foreign, or alien insurer that is authorized to write insurance in this state must file with the Commissioner any rate, rating plan, rating system, or underwriting rule for all personal private passenger motor vehicle insurance:

(1) For private passenger motor vehicle insurance providing only the mandatory minimum limits required by Code Section 33-34-4 and subsection (a) of Code Section 40-9-37, no such rate, rating plan, rating system, or underwriting rule shall become effective, nor may any premium be collected by any insurer thereunder, unless the filing has been received by the Commissioner in his or her office and such filing has been approved by the Commissioner or a period of 45 days has elapsed from the date such filing was received by the Commissioner during which time such filing has not been disapproved by the Commissioner. The Commissioner shall be authorized to extend such

45 day period by no more than 55 days at his or her discretion. If a filing is disapproved, notice of such disapproval order shall be given within 100 days of receipt of filing by the Commissioner, specifying in what respects such filing fails to meet the requirements of this chapter. The filer shall be given a hearing upon written request made within 30 days after the issuance of the disapproval order, and such hearing shall commence within 30 days after such request unless postponed by mutual consent. Such hearing, once commenced, may be postponed or recessed by the Commissioner only for weekends, holidays, or after normal working hours or at any time by mutual consent of all parties to the hearing. The Commissioner may also, at his or her discretion, recess any hearing for not more than two recess periods of up to 15 consecutive days each. In connection with any hearing or judicial review with respect to the approval or disapproval of such rates, the burden of persuasion shall fall upon the affected insurer or insurers to establish that the challenged rates are adequate, not excessive, and not unfairly discriminatory. After such a hearing, the Commissioner must affirm, modify, or reverse his or her previous action within the time period provided in subsection (a) of Code Section 33-2-23 relative to orders of the Commissioner. The requirement of approval or disapproval of a rate filing by the Commissioner under this subsection shall not prohibit actions by the Commissioner regarding compliance of such rate filing with the requirements of Code Section 33-9-4 brought after such approval or disapproval.

(2) For private passenger motor vehicle insurance other than that described in paragraph (1) of subsection (b) of Code Section 33-9-21, such rate, rating plan, rating system, or underwriting rule for all such private passenger motor vehicle insurance shall be effective upon filing and shall be implemented without approval of the Commissioner. This subsection shall apply to the entire private passenger motor vehicle insurance policy with limits above the mandatory minimum required by Code Section 33-34-4 and subsection (a) of Code Section 40-9-37 and shall apply to the entire private passenger motor vehicle policy with minimum limits if such policy has any additional nonmandatory coverage or coverages.

(c) When a rate filing of an insurer required under paragraph (1) of subsection (b) of this Code section is not accompanied by the information upon which the insurer supports the filing and the Commissioner does not have sufficient information to determine whether the filing meets the requirements of this chapter, then the Commissioner shall request in writing, within 20 days of the date he or she receives the filing, the specifics of such additional information as he or she requires, and the insurer shall be required to furnish such information, and in such event the 45 day period provided for in paragraph (1) of subsection

(b) of this Code section shall commence as of the date such information is furnished.

(d) Any domestic, foreign, or alien insurer that is authorized to write insurance in this state must file with the Commissioner any rate, rating plan, rating system, or underwriting rule at least 45 days prior to any indicated effective date for all insurance other than personal private passenger motor vehicle insurance. No rate, rating plan, rating system, or underwriting rule required to be filed under this subsection will become effective, nor may any premium be collected by any insurer thereunder, unless the filing has been received by the Commissioner in his office not less than 45 days prior to its effective date.

(e) When a rate filing of an insurer required under subsection (d) of this Code section results in any overall rate increase of 10 percent or more within any 12 month period, the Commissioner shall order an examination of that insurer to determine the accuracy of the claim reserves, the applicability of the claim reserve practices for the loss data used in support of such filing, and any other component of the rate filing; provided, however, that in the event the overall increase is less than 25 percent within any 12 month period and the Commissioner affirmatively determines that he or she has sufficient information to evaluate such rate increase and that the cost thereof would not be justified, he or she may waive all or part of such examination. In all other rate filings required under subsection (d) of this Code section, the Commissioner may order an examination of that insurer as provided in this subsection. Such examination shall be conducted in accordance with the provisions of Chapter 2 of this title. Upon notification by the Commissioner of his or her intent to conduct such examination, the insurer shall be prohibited from placing the rates so filed in effect until such examination has been reviewed and certified by the Commissioner as being complete. Such examination, if conducted by the Commissioner, shall be reviewed and certified within 90 days of the date such rate, rating plan, rating system, or underwriting rule is filed; provided, however, if the Commissioner makes an affirmative finding that the examination may not be completed within the 90 day period, he or she may extend such time for one additional 60 day period. Any examination required under this Code section shall be conducted in accordance with Chapter 2 of this title.

(f) Notwithstanding the provisions of subsection (d) of this Code section, in the event the filing of any rate, rating plan, rating system, or underwriting rule under subsection (d) of this Code section is not necessary, in the judgment of the Commissioner, to accomplish the purposes of this chapter as set forth in Code Section 33-9-1, then the Commissioner may exempt all domestic, foreign, and alien insurers from being required to file such rate, rating plan, rating system, or underwriting rule.

(g) Filings required pursuant to this Code section shall be accompanied by a fee or fees as provided in Code Section 33-8-1. (Code 1933, § 56-522.1, enacted by Ga. L. 1967, p. 684, § 1; Ga. L. 1978, p. 2073, § 2; Ga. L. 1980, p. 1063, § 1; Ga. L. 1982, p. 644, § 3; Ga. L. 1983, p. 629, §§ 2, 3; Ga. L. 1984, p. 22, § 33; Ga. L. 1985, p. 149, § 33; Ga. L. 1987, p. 870, § 2; Ga. L. 1990, p. 1409, § 16; Ga. L. 1991, p. 1608, § 1.6; Ga. L. 1992, p. 2725, § 17; Ga. L. 1994, p. 647, § 1; Ga. L. 1996, p. 705, § 4; Ga. L. 2008, p. 1192, § 4/SB 276; Ga. L. 2009, p. 42, § 2/SB 76.)

The 2008 amendment, effective October 1, 2008, designated the prior provisions of subsection (b) as the introductory language of subsection (b) and paragraph (b)(1); at the end of the introductory language, substituted a colon for a period; in paragraph (b)(1), in the first sentence, substituted "For private passenger motor vehicle insurance providing only the mandatory minimum limits required by Code Section 33-34-4 and subsection (a) of Code Section 40-9-37, no such rate, rating plan, rating system, or underwriting rule shall" for "No such rate, rating plan, rating system, or underwriting rule will" at the beginning; added paragraph (b)(2); and, in subsection (c), inserted "paragraph (1) of" twice, substituted "shall request" for "must request" and inserted commas after "requires" and "such information".

The 2009 amendment, effective July 1, 2009, in paragraph (a)(2), inserted a comma in the third sentence and deleted "Code Section 34-9-135, relating to required disclosure of costs by workers' compensation insurers," preceding "and any" in the fifth sentence.

Law reviews. — For survey article on insurance law, see 60 Mercer L. Rev. 191 (2008).

33-9-21.2. Petition for hearing by aggrieved insurer.

Any insurer aggrieved by the Commissioner's disapproval of any rate filing may petition the Commissioner for a hearing within ten days of the notification of such disapproval, unless otherwise specifically provided by law. A hearing conducted pursuant to this Code section shall be conducted in accordance with the provisions of Chapter 2 of this title. (Code 1981, § 33-9-21.2, enacted by Ga. L. 2002, p. 8, § 3.)

Effective date. — This Code section became effective March 11, 2002.

33-9-36. Unauthorized premiums; unlawful inducements.

(a) No broker or agent shall knowingly charge, demand, or receive a premium for any policy of insurance except in accordance with this chapter.

(b) No insurer or employee of such insurer and no broker or agent shall pay, allow, or give, or offer to pay, allow, or give, directly or indirectly as an inducement to insurance or after insurance has been effected, any rebate, discount, abatement, credit, or reduction of the premium named in a policy of insurance, or any special favor or advantage in the dividends or other benefits to accrue on such policy of insurance, or any valuable consideration or inducement whatever, not

specified in the policy of insurance, except to the extent provided for in an applicable filing. No insured named in a policy of insurance nor any employee of the insured shall knowingly receive or accept, directly or indirectly, any such rebate, discount, abatement, credit, or reduction of premium, or any special favor or advantage or valuable consideration or inducement.

(c) Nothing in this Code section shall be construed as prohibiting the payment of commissions or other compensation to duly licensed agents and brokers, nor as prohibiting any insurer from allowing or returning to its participating policyholders, members, or subscribers dividends, savings, or unabsorbed premium deposits.

(d) As used in this Code section the word "insurance" includes suretyship and the word "policy" includes bond.

(e) Nothing in this Code section shall be construed as prohibiting the payment for food or refreshments by an insurer or an agent, broker, or employee of an insurer for current or prospective clients during sales presentations and seminars, provided that no insurance or annuity applications or contracts are offered or accepted at such presentations or seminars. (Code 1933, § 56-535, enacted by Ga. L. 1967, p. 684, § 1; Ga. L. 2005, p. 563, § 3/HB 407; Ga. L. 2006, p. 72, § 33/SB 465.)

The 2005 amendment, effective July 1, 2005, added subsection (e).

The 2006 amendment, effective April 14, 2006, part of an Act to revise, modernize, and correct the Code, inserted a comma following "presentations and seminars" near the middle of subsection (e).

33-9-39. Restrictions on motor vehicle insurance surcharges relating to accidents involving law enforcement officers, firefighters, or emergency medical technicians.

No insurer shall surcharge the premium or rate charged on a policy of motor vehicle insurance that provides coverage for the personal motor vehicles of any law enforcement officer, firefighter, or emergency medical technician in this state for any accident:

(1) That occurred while the law enforcement officer, firefighter, or emergency medical technician was lawfully engaged in the performance of official duties; and

(2) For which the law enforcement officer, firefighter, or emergency medical technician furnishes proof, in the form of copies of the accident report, 9-1-1 emergency dispatch log, or the employing agency's documents, to the insurer of the condition provided in paragraph (1) of this Code section. (Code 1981, § 33-9-39, enacted by Ga. L. 1986, p. 1184, § 1; Ga. L. 1987, p. 3, § 33; Ga. L. 1988, p. 13, § 33; Ga. L. 1993, p. 542, § 1; Ga. L. 2004, p. 579, § 1; Ga. L. 2005, p. 660, § 5/HB 470.)

The 2004 amendment, effective May 13, 2004, substituted "that" for "which" in the introductory paragraph; in paragraph (1), substituted "That" for "Which" at the beginning and added "and" at the end; deleted former paragraph (2) which read: "Which occurred while the law enforcement officer, firefighter, or emergency medical technician was driving an official vehicle; and"; redesignated former paragraph (3) as present paragraph (2) and in that paragraph inserted "accident report, 911 emergency dispatch log, or the", substituted "condition" for "conditions", and substituted "paragraph (1)" for "paragraphs (1) and (2)" at the end.

The 2005 amendment, effective July 1, 2005, substituted "9-1-1" for "911" in paragraph (2).

33-9-40.1. Rates of workers' compensation policies issued to business entities with majority interest held by the same person; limitation on maintenance of reserves; investigations of complaints.

(a) An insurer shall not assign an adverse experience modification factor which is applicable to the rate of a workers' compensation insurance policy issued to a particular business entity to the rate of a workers' compensation policy issued to another business entity maintaining a separate payroll for federal and state tax purposes and engaging in a distinctly different business enterprise for the sole reason that the majority interest in both business entities is held by the same person.

(b) For experience rating purposes, no workers' compensation insurer shall maintain any case reserve for any claim in excess of the amount established by final judgment, by settlement, or otherwise. All reductions in case reserves shall be made and reported to the appropriate rating organization within 90 days. Any further adjustments upward in the case reserve shall only be made due to additional paid claims or a case reserve established on a claim which was previously closed but reopened due to a claimant's request for additional benefits. This limitation on the maintenance of reserves shall be enforced through this Code section, as well as through Code Section 33-9-21, relating to rate filings, Code Section 33-9-23, relating to examination of insurers, and any other appropriate enforcement procedures.

(c)(1) The Commissioner shall cause an investigation to be made of each complaint filed by a licensee under this title or under Article 5 of Chapter 9 of Title 34 or a person acting for or on behalf of such licensee against an insurer or workers' compensation group self-insurance fund alleging that such insurer or fund is:

(A) Using an improper rate;

(B) Using an improper classification; or

(C) Using an improper experience modification in issuing a contract of workers' compensation insurance.

(2) If the Commissioner finds the complaint to be justified, in addition to all other appropriate action under this title, the Commissioner may assess the cost of such investigation against the insurer or workers' compensation group self-insurance fund and retain the proceeds therefrom for reimbursement of the cost of conducting such investigation.

(3) If the person making the complaint is a licensee under this title or under Article 5 of Chapter 9 of Title 34 or a person acting for or on behalf of such licensee and the Commissioner finds the complaint not to be justified, the Commissioner may, in addition to all other appropriate action under this title:

(A) Assess the reasonable verified cost of such investigation against such person and retain the proceeds therefrom for reimbursement of the cost of conducting such investigation; and

(B) If such person files six or more complaints the Commissioner finds not to be justified in any 12 month period, assess an administrative penalty not to exceed $2,000.00 for the sixth and each subsequent complaint found to be not justified. (Code 1981, § 33-9-40.1, enacted by Ga. L. 1992, p. 1286, § 1; Ga. L. 1996, p. 705, § 5; Ga. L. 1997, p. 927, § 1; Ga. L. 2009, p. 42, § 3/SB 76.)

The 2009 amendment, effective July 1, 2009, in subsection (b), inserted a comma in the first sentence, substituted "shall" for "may" in the third sentence, and deleted "Code Section 34-9-135, relating to required disclosure of costs by workers' compensation insurers," preceding "and any" near the end of the fourth sentence.

33-9-40.2. Workers' compensation insurance premium discount for insured with drug-free workplace program.

(a) For each policy of workers' compensation insurance issued or renewed in the state on and after July 1, 1993, there shall be granted by the insurer not less than a 7 1/2 percent reduction in the premium for such policy if the insured has been certified by the State Board of Workers' Compensation as having a drug-free workplace program which complies with the requirements of Article 11 of Chapter 9 of Title 34 and has notified its insurer in writing of such certification.

(b) The premium discount provided by this Code section shall be applied to an insured's policy of workers' compensation insurance pro rata as of the date the insured receives certification by the State Board of Workers' Compensation and shall continue for as long as the insured maintains the certification as having a drug-free workplace; provided, however, that an insurer shall not be required to credit the actual amount of the premium discount to the account of the insured until the final premium audit under such policy. Certification by an insured shall be required for each year in which such premium discount is granted.

(c) The workers' compensation insurance policy of an insured shall be subject to an additional premium for the purposes of reimbursement of a previously granted premium discount and to cancellation in accordance with the provisions of the policy if it is determined by the State Board of Workers' Compensation that such insured misrepresented the compliance of its drug-free workplace program with the provisions of Article 11 of Chapter 9 of Title 34.

(d) Each insurer shall make an annual report to the rating and statistical organization designated by the Commissioner pursuant to this chapter illustrating the total dollar amount of drug-free workplace premium credit. Standard earned premium figures reported pursuant to this subsection on the aggregate calls for experience must reflect the effects of such credits. The net standard premium will then be the basis of any premium adjustment. The drug-free workplace credits must be reported under a unique classification code or unit statistical reports submitted to the rating and statistical organization designated by the Commissioner pursuant to this chapter.

(e) The Commissioner shall conduct a study to determine the impact of this chapter on reducing workers' compensation losses and on the impact of the premium credit provided pursuant to this Code section in encouraging employers to implement and maintain the program for which the credit is provided.

(f) The Commissioner shall be authorized to promulgate rules and regulations necessary for the implementation and enforcement of this Code section. (Code 1981, § 33-9-40.2, enacted by Ga. L. 1993, p. 1512, § 1; Ga. L. 1997, p. 1581, § 2; Ga. L. 2005, p. 1210, § 1/HB 327; Ga. L. 2006, p. 72, § 33/SB 465.)

The 2005 amendment, effective July 1, 2005, redesignated paragraph (b)(1) as subsection (b); in subsection (b), substituted "as long as the insured maintains the certification as having a drug-free workplace" for "a period not to exceed eight years" in the first sentence, substituted "each year" for "each of the eight years" in the second sentence, and deleted the former last sentence which read: "Thereafter, any premium discount pursuant to this article shall be determined from the insured's experience rating plan or in the case of an insured not rated upon experience, as provided in paragraph (2) of this subsection."; and deleted paragraph (b)(2) which read: "With respect to an insured which is not rated upon experience, any premium discount given an insured pursuant to this article after the initial eight-year period provided in paragraph (1) of this subsection shall be determined by the Commissioner based upon data received from the rating and statistical organization designated by the Commissioner pursuant to this chapter."

The 2006 amendment, effective April 14, 2006, part of an Act to revise, modernize, and correct the Code, inserted "that" following "however," near the beginning of the proviso in subsection (b).

33-9-41. Study of effect of 1987 legislation on loss experience; cooperation of insurers; report to General Assembly.

Reserved. Repealed by Ga. L. 2001, p. 4, § 33, effective February 12, 2001.

Editor's notes. — This Code section was based on Code 1981, § 33-9-41, enacted by Ga. L. 1987, p. 870, § 4.

33-9-42. Reduction in premiums for motor vehicle liability, first-party medical, and collision coverages for certain named drivers.

(a) For each personal or family-type policy of private passenger motor vehicle insurance issued or issued for delivery in this state, there shall be offered by the insurer a reduction of not less than 10 percent in premiums for motor vehicle liability, first-party medical, and collision coverages to the policyholder if all named drivers, as listed or who should be listed on the policy application or provided in information subsequent to such application, of each motor vehicle covered by such policy satisfy the requirements of subsection (b) or subsection (c), as applicable, of this Code section.

(b) Reductions in premiums shall be available if all named drivers who are 25 years of age or older:

(1) Have committed no traffic offenses for the prior three years or since the date of licensure, whichever is shorter;

(2) Have had no claims based on fault against an insurer for the prior three years; and

(3) Complete one of the following types of driving courses:

(A) A course in defensive driving of not less than six hours from a driver improvement clinic or commercial or noncommercial driving school approved by and under the jurisdiction of the Department of Driver Services;

(B) An emergency vehicles operations course at the Georgia Public Safety Training Center;

(C) A course in defensive driving of not less than six hours from a driver improvement program which is administered by a nonprofit organization such as the American Association of Retired People, the American Automobile Association, the National Safety Council, or a comparable organization and which meets the standards promulgated by the Department of Driver Services pursuant to subsection (f) of this Code section; or

(D) A course in defensive driving of not less than six hours offered by an employer to its employees and their immediate families, which course has been approved by the Department of Driver Services.

(c) Reductions in premiums shall be available if all named drivers who are under 25 years of age:

(1) Have committed no traffic offenses for the prior three years or since the date of licensure, whichever is shorter;

(2) Have had no claims based on fault against an insurer for the prior three years; and

(3) Complete a preparatory course offered to new drivers of not less than 30 hours of classroom training and not less than six hours of practical training by a driver's training school approved by and under the jurisdiction of the Department of Driver Services or by an accredited secondary school, junior college, or college.

(d) Upon completion of one of the driving courses specified in paragraph (3) of subsection (b) or paragraph (3) of subsection (c), as applicable, of this Code section by each named driver, eligibility for reductions in premiums for such policy shall continue for a period of three years, provided any named driver under such policy does not commit a traffic offense or have a claim against the policy based on any such driver's fault.

(e) The Department of Driver Services shall assure through the supervision of driver improvement clinics, emergency vehicles operations courses, driver improvement programs administered by nonprofit organizations, and commercial or noncommercial driving schools approved by the Department of Driver Services that defensive driving courses shall be available and accessible wherever practicable as determined by the department to licensed drivers throughout the state.

(f) Each insurer providing premium discounts under this Code section shall provide, upon the request of the Commissioner, information regarding the amount of such discounts in a form acceptable to the Commissioner.

(g) The power of supervision granted to the Department of Driver Services over driver improvement programs administered by nonprofit organizations under this Code section shall be limited to the establishment of minimum standards and requirements relative to the content of specific courses offered by such programs and relative to investigation and resolution of any complaints directed towards the content or operation of any course by a person enrolled in such course. The Department of Driver Services may adopt rules and regulations necessary to carry out the provisions of this subsection. The Department of

Driver Services shall not require a nonprofit organization to obtain a license or permit or to pay a fee in order to administer a driver improvement program in the state. The Department of Driver Services shall not require a commercial driving school licensed by such department to obtain an additional license to teach a defensive driving course, as described in subparagraph (b)(3)(A) or paragraph (3) of subsection (c) of this Code section, at any location in this state.

(h) Nothing in this Code section shall prevent an insurer from offering the reduction in premium specified in subsection (a) of this Code section to a driver who does not meet all of the requirements of subsection (b) or subsection (c), as applicable, of this Code section. (Code 1981, § 33-9-42, enacted by Ga. L. 1991, p. 1608, § 1.7; Ga. L. 1992, p. 2464, § 1; Ga. L. 1993, p. 611, § 1; Ga. L. 2002, p. 415, § 33; Ga. L. 2005, p. 334, § 13-1/HB 501.)

The 2002 amendment, effective April 18, 2002, part of an Act to revise, modernize, and correct the Code, substituted "Department of Motor Vehicle Safety" for "Department of Public Safety" throughout the Code section.

The 2005 amendment, effective July 1, 2005, substituted "Department of Driver Services" for "Department of Motor Vehicle Safety" throughout subsections (b), (c), (e), and (g).

CHAPTER 10

ASSETS AND LIABILITIES

33-10-1. Assets considered in determining financial condition of insurers — Generally.

In any determination of the financial condition of an insurer, there shall be allowed as assets only such assets as are owned by the insurer and which consist of:

(1) Cash in the possession of the insurer or in transit under its control, including the true balance of any deposit in a solvent bank, trust company, a savings and loan association, or a building and loan association;

(2) Investments, securities, properties, and loans acquired or held in accordance with this title and in connection therewith the following items:

(A) Interest due or accrued on any bond or evidence of indebtedness which is not in default and which is not valued on a basis including accrued interest;

(B) Declared and unpaid dividends on stock and shares, unless such amount has otherwise been allowed as an asset;

(C) Interest due or accrued upon a collateral loan in an amount not to exceed one year's interest thereon;

(D) Interest due or accrued on deposits in solvent banks, trust companies, savings and loan associations, or building and loan associations and interest due or accrued on other assets, if such interest is in the judgment of the Commissioner a collectable asset;

(E) Interest due or accrued on a mortgage loan, in an amount not exceeding in any event the amount, if any, of the excess of the value of the property less delinquent taxes on the property over the unpaid principal; but in no event shall interest accrued for a period in excess of 18 months be allowed as an asset;

(F) Rent due or accrued on real property if such rent is not in arrears for more than three months and rent more than three months in arrears if the payment of such rent be adequately secured by property held in the name of the tenant and conveyed to the insurer as collateral; or

(G) The unaccrued portion of taxes paid prior to the due date on real property;

(3) Electronic and mechanical machines and software, as such term is defined in paragraph (74) of Code Section 11-9-102, constituting a data processing, record-keeping, or accounting system if the cost of such system does not exceed 10 percent of admitted assets or $7,500,000.00, whichever is less;

(4) Premium notes, policy loans, and other policy assets and liens on policies and certificates of life insurance and annuity contracts and accrued interest thereon, in an amount not exceeding the legal reserve and other policy liabilities carried on each individual policy;

(5) The net amount of uncollected and deferred premiums and annuity considerations in the case of a life insurer;

(6) Premiums in the course of collection, other than for life insurance and annuity considerations, not more than three months past due, less commissions payable thereon. The foregoing limitation shall not apply to premiums payable directly or indirectly by the United States government or by any state or by any of their instrumentalities;

(7) Installment premiums other than life insurance premiums to the extent of the unearned premium reserves carried thereon;

(8) Notes and similar written obligations not past due taken for premiums other than life insurance premiums on policies permitted to be issued on such basis to the extent of the unearned premium reserves carried thereon;

(9) The full amount of reinsurance recoverable by a ceding insurer from a solvent reinsurer and which reinsurance is authorized under Code Section 33-7-14;

(10) Amounts receivable by an assuming insurer representing funds withheld by a solvent ceding insurer under a reinsurance treaty;

(11) Deposit or equities recoverable from underwriting associations, syndicates, and reinsurance funds or from any suspended banking institution to the extent deemed by the Commissioner available for the payment of losses and claims and at values to be determined by him;

(12) All assets, whether or not consistent with this Code section, as may be allowed pursuant to the annual statement form approved by the Commissioner for the kinds of insurance to be reported upon therein; and

(13) Other assets, not inconsistent with this Code section, deemed by the Commissioner to be available for the payment of losses and claims at values to be determined by the Commissioner. (Code 1933, § 56-901, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1980, p. 1108, § 2; Ga. L. 1995, p. 481, § 1; Ga. L. 1996, p. 6, § 33; Ga. L. 2008, p. 469, § 1/SB 347.)

The 2008 amendment, effective May 12, 2008, in paragraph (3), inserted "and software, as such term is defined in paragraph (74) of Code Section 11-9-102," near the beginning and added "or $7,500,000.00, whichever is less" at the end.

33-10-9. Required reserves — Employers' liability and workers' compensation insurance.

Reserved. Repealed by Ga. L. 2005, p. 655, § 1, effective May 2, 2005.

Editor's notes. — This Code section was based on Code 1933, § 56-909, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1982, p. 3, § 33.

CHAPTER 11

INVESTMENTS

ARTICLE 1

INVESTMENTS OF CERTAIN INSURERS

33-11-13. Authorized investments generally — Obligations of political subdivisions or public authorities of states of United States, District of Columbia, or government of Canada.

An insurer may invest in the obligations of any county, any incorporated city, town, or village, any school district, water district, sewer district, road district, or any special district, or any other political subdivision or public authority of any state, territory, or insular possession of the United States, or of the District of Columbia, or of the Canadian cities that have a population of over 25,000 according to the most recent official Census of Canada, which has not defaulted for a period of 120 days in the payment of interest upon, or for a period of more than one year in the payment of principal of, any of its bonds, notes, warrants, certificates of indebtedness, securities, or any other interest-bearing obligation during the five years immediately preceding the acquisition of the investment. (Code 1933, § 56-1012, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1999, p. 592, § 6; Ga. L. 2006, p. 767, § 1/SB 385.)

The 2006 amendment, effective May 3, 2006, substituted "Canadian cities that have a population of over 25,000 according to the most recent official Census of Canada" for "Canadian cities having a population of over 25,000 according to the most recent official census".

ARTICLE 2

INVESTMENTS OF LIFE, ACCIDENT AND SICKNESS, PROPERTY, AND CASUALTY INSURERS

33-11-66. Cumulative nature of Code section; variable annuity contract; separate accounts; conduct of business; licensed or organized to do business in state; Commissioner's role.

(a) This Code section is cumulative of and in addition to the authority granted by any other law of this state relating to separate accounts for insurance companies or to annuity contracts on a variable basis and shall not be deemed to repeal or affect the provisions of Code Section 33-11-65 dealing with the group variable annuity contracts referred to in subsection (f) of Code Section 33-11-65.

(b) When used in this Code section, the term "variable annuity contract" shall mean any individual or group contract issued by an insurance company or annuity company providing for annuity benefits and incidental contractual payments or values which vary in whole or in part so as to reflect investment results of any segregated portfolio of investments or of a designated separate account or accounts in which amounts received or retained in connection with any of the contracts have been placed.

(c) Any domestic life insurance company may establish one or more separate accounts and may allocate to those accounts amounts to provide for annuities (and benefits incidental thereto) payable in fixed or variable amounts or both.

(d) Except as provided in subsection (f) of this Code section, amounts allocated to any separate account and accumulations thereon may be invested and reinvested without regard to any requirements or limitations prescribed by the laws of this state governing the investments of domestic life insurance companies, provided that, to the extent that the company's reserve liability with regard to benefits guaranteed as to amount and duration and funds guaranteed as to principal amount or stated rate of interest is maintained in any separate account, a portion of the assets of such separate account at least equal to the reserve liability shall be invested in accordance with the laws of this state governing the investment of reserves of life insurance companies. The investments in the separate account or accounts shall not be taken into account in applying the investment limitations applicable to other investments of the company.

(e) To the extent any such domestic company deems it necessary to comply with any applicable federal or state laws, the company, with

respect to any separate account, including without limitation any separate account which is a management investment company or a unit investment trust, may provide for persons having an interest in such separate account appropriate voting and other rights and special procedures for the conduct of the business of such account, including without limitation, special rights and procedures relating to investment policy, investment advisory services, selection of independent public accountants, and the selection of a committee, the members of which need not be otherwise affiliated with the company, to manage the business of the account. This subsection shall not affect existing laws pertaining to the voting rights of the life insurance company's stockholders or policyholders except as provided in this Code section.

(f) No domestic company shall, for any separate account, purchase the voting securities of a single issuer if such purchase would result in such company, and all domestic insurance companies, directly or indirectly controlling, controlled by, or under common control with the company and holding in the company's or companies' separate account or accounts an amount in excess of 10 percent of the total issued and outstanding voting securities of the issuer, provided that this limitation shall not apply with respect to securities held in separate accounts, the voting rights in which are exercisable in accordance with instructions from persons having interests in such accounts. This limitation shall not apply to the investment for a separate account in the securities of an investment company registered under the Investment Company Act of 1940.

(g) No sale, exchange, or other transfer of assets may be made by any domestic company between any of its separate accounts or between any other investment account and one or more of its separate accounts unless, in case of a transfer into a separate account, the transfer is made solely to establish the account or to support the operation of the contracts with respect to the separate account to which the transfer is made and unless the transfer, whether into or from a separate account, is made by transfer of cash or by a transfer of securities having a readily determinable market value, provided that transfer of securities is approved by the Commissioner. The Commissioner may approve other transfers among such accounts if, in his or her opinion, the transfers would not be inequitable.

(h) The income, if any, and gains and losses, realized or unrealized, from assets allocated to each account shall be credited to or charged against the account without regard to income, gains, or losses of the company.

(i) Unless otherwise approved by the Commissioner, assets allocated to a separate account shall be valued at their market value on the date of valuation or, if there is no readily available market, as provided

under the terms of the contract or the rules or other written agreement applicable to such separate account, provided that the portion of the assets of the separate account equal to the company's reserve liability with regard to the guaranteed benefits and funds referred to in subsection (d) of this Code section, if any, shall be valued in accordance with the rules otherwise applicable to the company's assets. The reserve liability for variable annuity contracts shall be determined in accordance with actuarial procedures that recognize the variable nature of the benefits provided and any mortality guarantees.

(j) The amounts held in any separate account shall not be chargeable with liabilities arising out of any other business the company may conduct but shall be held and applied exclusively for the benefit of the owners or beneficiaries of the variable annuity contracts applicable thereto.

(k) Each domestic life insurance company shall have the power within the limits of its corporate charter to do all things necessary under any applicable state or federal law in order that variable annuity contracts may be lawfully sold or offered for sale including, without limitation, the power to provide for management of a separate account by persons who may otherwise be unaffiliated with the life insurance company and the power to grant in connection with such contracts such voting rights as are set forth in subsection (e) of this Code section. Each domestic life insurance company may allocate from its general accounts to each separate account established under this Code section an initial cash amount necessary to meet minimum capitalization requirements for such account as prescribed by the Securities and Exchange Commission, provided that the total of all such allocations shall not exceed 10 percent of the company's assets or $1 million, whichever is less. Any allocation may be withdrawn when sufficient amounts have been received by the company in connection with variable annuity contracts and allocated to a separate account to meet the minimum capitalization requirement.

(l) Amounts allocated to a separate account in the exercise of the power granted by this Code section shall be owned by the company, and the company shall not be, or hold itself out to be, a trustee with respect to such amounts.

(m) Any variable annuity contract providing benefits payable in variable amounts issued under this Code section shall contain a statement of the essential features of the procedure to be followed by the company in determining the dollar amount of such variable benefits. Any contract, including a group contract and certificate in evidence or variable benefits issued under such contract, shall state that such dollar amount will vary to reflect investment experience and shall contain on its first page a statement to the effect that benefits under the contract are on a variable basis.

(n) No company shall deliver or issue for delivery variable annuity contracts within this state unless it is licensed or organized to do a life insurance or annuity business in this state or is organized as a nonprofit educational corporation in its state of domicile and issues variable annuity contracts solely for the purpose of aiding and strengthening nonproprietary and nonprofit-making colleges, universities, and other institutions engaged primarily in education or research and the Commissioner is satisfied that its condition or method of operation in connection with the issuance of such contracts will not render its operation hazardous to the public or its policyholders in this state. In this connection, the Commissioner shall consider among other things:

(1) The history and financial condition of the company;

(2) The character, responsibility, and fitness of the officers and directors of the company; and

(3) The law and regulation under which the company is authorized in the state of domicile to issue variable contracts.

(o) The Commissioner shall have sole and exclusive authority to regulate the issuance or sale of the contracts and to issue such reasonable rules and regulations as may be necessary to carry out the purposes and provisions of this Code section; and the contracts, the companies which issue them, and the agents or other persons who sell them shall not be subject to Chapter 5 of Title 10, the "Georgia Uniform Securities Act of 2008," in the sale of the contracts.

(p) Notwithstanding any other laws of this state, no individual shall, within this state, sell or offer for sale variable annuity contracts as defined in this Code section unless the individual shall have both a valid and current life insurance license and variable contract license issued by the Commissioner. No license shall be issued unless and until the Commissioner is satisfied, after examination, except as provided for in Code Section 33-23-16, that the person is by training, knowledge, ability, and character qualified to act as such a variable annuity agent. The Commissioner may reject any application or suspend or revoke or refuse to renew any variable contract agent's license upon any ground that would bar the applicant or the agent from being licensed to sell life insurance contracts in this state or for the violation of any federal or state securities laws or regulations. The rules governing any proceedings relating to the suspension or revocation of a life insurance agent's license shall also govern any proceedings for the suspension or revocation of a variable contract agent's license. Renewal of a variable contract agent's license shall follow the same procedure established for renewal of an agent's license to sell life insurance contracts in this state.

(q) No contract or agreement made pursuant to this Code section or policy or certificate issued under this Code section shall be construed to

violate Code Section 33-25-9, and the sale or offer of any policy or certificate shall not be deemed an unfair method of competition or an unfair or deceptive act or practice in the business of insurance in violation of paragraph (7) and subparagraphs (B) and (C) of paragraph (8) of Code Section 33-6-4.

(r) Except for paragraphs (1), (5), and (6) of subsection (b) of Code Section 33-28-2 and except as otherwise provided in this Code section, all pertinent provisions of this title shall apply to separate accounts and variable annuity contracts relating thereto. The Commissioner, by regulation, may require that any individual variable annuity contract delivered or issued for delivery in this state contain provisions as to grace period and reinstatement appropriate for a variable annuity contract. (Code 1981, § 33-11-66, enacted by Ga. L. 1999, p. 592, § 12; Ga. L. 2001, p. 925, § 3; Ga. L. 2008, p. 381, § 10/SB 358.)

The 2001 amendment, effective July 1, 2002, in subsection (p), substituted "contract agent's license" for "annuity agent's license" in three places throughout this subsection, substituted "individual" for "person" twice in the first sentence, substituted "contract license" for "annuity license" at the end of the first sentence, and inserted ", except as provided for in Code Section 33-23-16" near the middle of the second sentence.

The 2008 amendment, effective July 1, 2009, substituted "'Georgia Uniform Securities Act of 2008,'" for "'Georgia Securities Act of 1973,'" near the end of subsection (o).

33-11-67. Variable contract insurance policies; separate accounts; power of company; statement of essential features in determining benefits; certificate of authority; Commissioner's role; insurance license required.

(a) As used in this Code section, "variable life insurance policy" means any individual or group policy issued by an insurance company providing for life insurance and benefits incidental thereto, under which payments or values may vary in whole or in part so as to reflect investment results of any segregated portfolio of investments or of a designated separate account or accounts in which amounts received or retained in connection with any of such policies have been placed.

(b) A domestic life insurance company may establish one or more separate accounts and may allocate to the accounts amounts including without limitation proceeds applied under optional modes of settlement or under dividend options to provide for life insurance and benefits incidental thereto, payable in variable amounts, subject to the following:

(1) The income, gains, and losses, realized or unrealized, from assets allocated to a separate account shall be credited to or charged against the account, without regard to other income, gains, or losses of the company;

(2) Except as provided in paragraph (4) of this subsection, amounts allocated to any separate account and accumulations thereon may be invested and reinvested without regard to any requirements or limitations prescribed by the laws of this state governing the investments of domestic life insurance companies, provided that, to the extent that the company's reserve liability with regard to benefits guaranteed as to amount and duration and funds guaranteed as to principal amount or stated rate of interest is maintained in any separate account, a portion of the assets of the separate account at least equal to the reserve liability shall be invested in accordance with the laws of this state governing the investment of reserves of life insurance companies. The investments in the separate account or accounts shall not be taken into account in applying the investment limitations applicable to other investments of the company;

(3) To the extent any domestic company deems it necessary to comply with any applicable federal or state laws, the company, with respect to any separate account, including without limitation any separate account which is a management investment company or a unit investment trust, may provide for persons having an interest therein appropriate voting and other rights and special procedures for the conduct of the business of the account, including without limitation special rights and procedures relating to investment policy, investment advisory services, selection of independent public accountants, and the selection of a committee, the members of which need not be otherwise affiliated with the company, to manage the business of such account. This paragraph shall not affect existing laws pertaining to the voting rights of the life insurance company's stockholders or policyholders except as provided in paragraph (4) of this subsection;

(4) No domestic company shall, for any separate account, purchase the voting securities of a single issuer if the purchase would result in the company and all domestic insurance companies directly or indirectly controlling, controlled by, or under common control with the company and holding in the company's or companies' separate account or accounts an amount in excess of 10 percent of the total issued and outstanding voting securities of the issuer, provided that this limitation shall not apply with respect to securities held in separate accounts, the voting rights in which are exercisable in accordance with instructions from persons having interest in the accounts. This limitation shall not apply to the investment for a separate account in the securities of an investment company registered under the Investment Company Act of 1940;

(5) Unless otherwise approved by the Commissioner, assets allocated to a separate account shall be valued at their market value on

the date of valuation or, if there is no readily available market, as provided under the terms of the policy or the rules or other written agreement applicable to the separate account, provided that, unless otherwise approved by the Commissioner, the portion, if any, of the assets of such separate account equal to the company's reserve liability with regard to the guaranteed benefits and funds referred to in paragraph (2) of this subsection shall be valued in accordance with the rules otherwise applicable to the company's assets;

(6) Amounts allocated to a separate account in the exercise of the power granted by this Code section shall be owned by the company, and the company shall not be, nor hold itself out to be, a trustee with respect to such amounts. If and to the extent so provided under the applicable contracts, that portion of the assets of any such separate account equal to the reserves and other contract liabilities with respect to the account shall not be chargeable with liabilities arising out of any other business the company may conduct; and

(7) No sale, exchange, or other transfer of assets may be made by a company between any of its separate accounts or between any other investment account and one or more of its separate accounts unless, in case of a transfer into a separate account, the transfer is made solely to establish the account or to support the operation of the policies with respect to the separate account to which the transfer is made and unless the transfer, whether into or from a separate account, is made by a transfer of cash or by a transfer of securities having a readily determinable market value, provided that the transfer of securities is approved by the Commissioner. The Commissioner may approve other transfers among the accounts if, in his or her opinion, the transfers would not be inequitable.

(c) Each domestic life insurance company shall have the power within the limits of its corporate charter to do all things necessary under any applicable state or federal law in order that variable life insurance policies may be lawfully sold or offered for sale including, without limitation, the power to provide for management of a separate account by persons who may otherwise be unaffiliated with the life insurance company and the power to grant in connection with the policies such voting rights as are set forth in paragraph (3) of subsection (b) of this Code section. Each domestic life insurance company may allocate from its general accounts to each separate account established under this Code section an initial cash amount necessary to meet minimum capitalization requirements for such account as prescribed by the Securities and Exchange Commission, provided that the total of all of the allocations shall not exceed 10 percent of the company's assets or $1 million, whichever is less. Any allocation may be withdrawn when sufficient amounts have been received by the company in connection

with variable life insurance policies and allocated to a separate account to meet the minimum capitalization requirement.

(d) Any variable life insurance policy issued under this Code section shall contain a statement of the essential features of the procedure to be followed by the company in determining the dollar amount of variable benefits provided under such policy. Any policy, including a group contract and certificates in evidence of variable benefits issued thereunder, shall state that the dollar amount will vary to reflect investment experience and shall contain on its first page a statement to the effect that benefits under such policy are on a variable basis.

(e) No company shall deliver or issue for delivery variable life insurance policies within this state unless it has a current certificate of authority to transact life insurance in this state and the Commissioner is satisfied that its condition or method of operations in connection with the issuance of such policies will not render its operation hazardous to the public or its policyholders in this state. In this connection, the Commissioner shall consider among other things:

(1) The history and financial condition of the company;

(2) The experience, character, responsibility, and fitness of the officers and directors of the company; and

(3) The law and regulation under which the company is authorized in the state of domicile to issue variable life insurance policies.

(f) The Commissioner shall have sole and exclusive authority to regulate the solicitation, sale, and issuance of variable life insurance policies and to issue any reasonable rules and regulations as may be necessary to carry out the purposes and provisions of this Code section; and the policies, the companies which issue them, and the agents or other persons who sell them shall not be subject to Chapter 5 of Title 10, the "Georgia Uniform Securities Act of 2008," in the sale of the policies.

(g) Notwithstanding any other laws of this state, no individual shall, within this state, sell or offer for sale variable life insurance contracts as defined in this Code section unless such individual shall have both a valid and current life insurance license and variable contract insurance license issued by the Commissioner. No license shall be issued unless and until the Commissioner is satisfied, after examination, except as provided for in Code Section 33-23-16, that the individual is by training, knowledge, ability, and character qualified to act as such a variable contract insurance agent. The Commissioner may reject any application or suspend or revoke or refuse to renew any variable contract insurance agent's license upon any ground that would bar the applicant or the agent from being licensed to sell life insurance contracts in this state or for the violation of any federal or state securities laws or

regulations. The rules governing any proceedings relating to the suspension or revocation of a life insurance agent's license shall also govern any proceedings for the suspension or revocation of a variable contract insurance agent's license. Renewal of a variable contract insurance agent's license shall follow the same procedure established for renewal of an agent's license to sell life insurance contracts in this state.

(h) No variable life insurance policy or certificate issued pursuant to this Code section shall be construed to violate Code Section 33-25-9, and the sale or offer of any such policy or certificate shall not be deemed an unfair method of competition or an unfair or deceptive act or practice in the business of insurance in violation of paragraph (7) and subparagraphs (B) and (C) of paragraph (8) of subsection (b) of Code Section 33-6-4.

(i)(1) Except for paragraphs (1), (5), (6), (7), and (8) of subsection (a) of Code Section 33-25-3, Code Section 33-25-4, and paragraph (1) of Code Section 33-27-3 and except as otherwise provided in this Code section, all pertinent provisions of this title shall apply to separate accounts and variable life insurance policies relating to such accounts. The Commissioner, by regulation, may require that any individual variable life insurance policy delivered or issued for delivery in this state contain provisions as to grace, reinstatement, and nonforfeiture appropriate for that policy; and any such group variable life insurance policy shall contain a provision for grace and nonforfeiture appropriate to that policy.

(2) The reserve liability for variable life insurance policies shall be determined in accordance with actuarial procedures approved by the Commissioner that recognize the variable nature of the benefits provided and any mortality guarantees. (Code 1981, § 33-11-67, enacted by Ga. L. 1999, p. 592, § 12; Ga. L. 2001, p. 925, § 4; Ga. L. 2008, p. 381, § 10/SB 358.)

The 2001 amendment, effective July 1, 2002, in subsection (g), substituted "individual" for "person" in three places, substituted "variable contract insurance" for "variable life insurance" in five places, and inserted "except as provided for in Code Section 33-23-16," near the middle of the second sentence.

The 2008 amendment, effective July 1, 2009, substituted "'Georgia Uniform Securities Act of 2008,'" for "'Georgia Securities Act of 1973,'" near the end of subsection (f).

CHAPTER 14

DOMESTIC STOCK AND MUTUAL INSURERS

ARTICLE 1

GENERAL PROVISIONS

33-14-1. Applicability of chapter.

Law reviews. — For note on 2000 amendments of O.C.G.A. §§ 33-14-5, 33-14-6, 33-14-8, 33-14-24, 33-14-25, see 17 Ga. St. U. L. Rev. 212 (2000).

33-14-10. Sale of subscriptions for insurance securities and sale offer of insurance securities.

(a) As used in this Code section, "insurance securities" means the securities of an insurer who is the issuer of a security as the word "security" is defined in Chapter 5 of Title 10, the "Georgia Uniform Securities Act of 2008."

(b) No person shall sell, offer for sale, or propose to sell to the public any subscriptions for insurance securities in this state unless the insurer which shall issue the insurance securities provided in the subscription has applied for, qualified for, received, and holds authority to transact insurance in this state from the Commissioner, or has an effective registration of the subscriptions for insurance securities with the Securities and Exchange Commission, or unless the subscriptions are sold by or through a broker in accordance with the rules of the Securities and Exchange Commission.

(c) No person shall sell, offer for sale, or propose to sell to the public any insurance securities in this state unless the insurer which shall issue said insurance securities has applied for, qualified for, received, and holds authority to transact insurance in this state from the Commissioner, or has an effective registration of such securities with the Securities and Exchange Commission, or unless such securities are sold by or through a broker in accordance with the rules of the Securities and Exchange Commission.

(d) Nothing contained in this Code section shall be deemed to repeal any of Chapter 5 of Title 10 but shall be supplementary and in addition thereto.

(e) Any person violating this Code section shall be guilty of a misdemeanor.

(f) The Commissioner shall be authorized to withhold the authority of any insurer to transact insurance in this state so long as any person who has been convicted of any offense defined in this Code section remains an officer, employee, or agent of the person or entity seeking the authority to transact insurance. (Code 1933, § 1506.1, enacted by Ga. L. 1966, p. 217, § 1; Ga. L. 1992, p. 6, § 33; Ga. L. 2008, p. 381, § 10/SB 358.)

The 2008 amendment, effective July 1, 2009, substituted "'Georgia Uniform Securities Act of 2008.'" for "'Georgia Securities Act of 1973.'" at the end of subsection (a).

ARTICLE 2

DOMESTIC STOCK INSURERS

33-14-41. Dividends payable only out of realized profits or upon special approval of Commissioner.

Law reviews. — For note on 2000 amendment of O.C.G.A. § 33-14-41, see 17 Ga. St. U. L. Rev. 212 (2000).

ARTICLE 3

DOMESTIC MUTUAL INSURERS

33-14-76. Authorization and procedure for conversion of mutual insurer to stock insurer.

(a) A mutual insurer may become a stock insurer under any plan and procedure as may be approved by the Commissioner.

(b) The Commissioner shall not approve the plan or procedure unless:

(1) It is equitable to the insurer's members;

(2) It is subject to approval by vote of not less than 60 percent of the insurer's current members who cast votes on such plan in person, by proxy, or by mail at a meeting of members called for the purpose pursuant to 20 days' notice and procedure as may be approved by the Commissioner;

(3) If a life insurer, the right to vote may be limited as the bylaws shall provide to members whose policies are other than term or group policies and have been in effect for more than one year;

(4) The equity of each policyholder in the insurer is determinable under a fair formula approved by the Commissioner, which equity shall be based upon not less than the insurer's entire statutory surplus after deducting contributed or borrowed surplus funds plus a reasonable present equity in its reserves and in all nonadmitted assets, less expenses of the conversion;

(5) The policyholders entitled to participate in the purchase of stock or distributing of assets shall include all current policyholders who own a policy for which all premiums due have been fully paid on the date the plan was adopted by the board of directors of the insurer;

(6) The plan, as elected by the insurer and voted upon by the members, gives to each policyholder of the insurer as specified in paragraph (5) of this subsection one of the following:

(A)(i) A preemptive right to acquire his or her proportionate part of all of the proposed capital stock of the insurer within a designated reasonable period and to apply upon the purchase price thereof the amount of his or her equity in the insurer as determined in paragraph (4) of this subsection.

(ii) Shares are so offered to policyholders at a price not greater than that to be thereafter offered to others.

(iii) The plan provides for payment, to each policyholder not electing to apply his or her equity in the insurer for or upon the purchase price of stock to which preemptively entitled, of cash in the amount of not less than 50 percent of the amount of his or her equity not so used for the purchase of stock, which cash payment together with stock so purchased, if any, shall constitute full payment and discharge of the policyholder's equity as an owner of the mutual insurer;

(B)(i) Payment in cash to each policyholder of 100 percent of his or her equity in the insurer, as determined in paragraph (4) of this subsection.

(ii) If a life insurer, payment may be provided as a paid-up life insurance policy with a cash value equal to 100 percent of the

policyholder's equity in the insurer; provided, however, that the insurer may not impose a surrender charge on any policyholder electing to surrender his or her paid-up life insurance policy for its cash value; or

(C)(i) A preemptive right to acquire a percentage of his or her proportionate part of all of the proposed capital stock of the insurer within a designated reasonable period and to apply upon the purchase price thereof that same percentage amount of his or her equity in the insurer as determined in paragraph (4) of this subsection.

(ii) Shares are so offered to policyholders at a price not greater than that to be thereafter offered to others.

(iii) The plan provides for payment, to each policyholder not electing to apply his or her equity in the insurer for or upon the purchase price of stock to which preemptively entitled, of cash in the amount of not less than 50 percent of the amount of his or her equity not so used for the purchase of stock, which cash payment together with stock so purchased, if any, shall constitute full payment and discharge of the policyholder's equity as an owner of the mutual insurer; and

(7) The plan when completed would provide for the converted insurer paid-in capital stock in an amount not less than the minimum paid-in capital required of a domestic stock insurer transacting like kinds of insurance together with surplus funds in an amount required for the insurer under this title.

(c) The corporate existence of a mutual insurer converting to a stock insurer pursuant to this Code section shall not terminate upon such conversion, but the new stock insurer shall be deemed to be a continuation of the mutual insurer and to have been organized on the date the mutual insurer was originally organized.

(d) The insurer which has converted from a mutual to a stock company may continue to use its old name or may change its name pursuant to the laws of this state. In the event the converted insurer continues to use the word mutual in its name, then it shall include words after its name identifying the converted insurer as a stock insurer.

(e)(1) The Commissioner may approve any plan or procedure to become a stock insurer filed by a mutual insurer which at the time of the filing of such plan or procedure is insolvent or does not meet the minimum statutory surplus requirements, provided that such plan or procedure, on the date such plan or procedure is completed, would provide for the converted insurer paid-in capital stock in an amount

not less than the minimum paid-in capital required of a domestic stock insurer transacting like kinds of insurance together with surplus funds in an amount required for the insurer under this title. The mutual insurer may provide in the plan or procedure for the waiver of the requirement to give notice to policyholders, to obtain policyholder approval of the plan or procedure, or to make any distribution of the policyholders' equity in the mutual insurer to any policyholder where the value of the mutual insurer, due to its insolvency or its failure to meet minimum statutory surplus requirements, does not warrant any such notice, approval, or distribution under the circumstances, including the expense involved in such a distribution.

(2) A plan or procedure described in paragraph (1) of this subsection must include a description of how the mutual insurer will meet the statutory surplus and capital requirements on the date the plan or procedure is completed, which may involve the issuance and sale directly to one or more purchasers of the capital stock of the converted insurer or of a corporation which will own 100 percent of the converted insurer. (Ga. L. 1912, p. 119, § 16; Code 1933, § 56-1308; Code 1933, § 56-1537, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1992, p. 6, § 33; Ga. L. 1994, p. 300, § 2; Ga. L. 2009, p. 676, § 1/HB 550.)

The 2009 amendment, effective July 1, 2009, in subparagraph (b)(6)(B), designated the existing provisions as division (b)(6)(B)(i), added the period at the end of division (b)(6)(B)(i), added the (b)(6)(B)(ii) designation, and added "If a life insurer, payment may be provided as a paid-up life insurance policy with a cash value equal to 100 percent of the policyholder's equity in the insurer; provided, however, that the insurer may not impose a surrender charge on any policyholder electing to surrender his or her paid-up life insurance policy for its cash value;" in division (b)(6)(B)(ii).

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2009, "; and" was added at the end of division (b)(6)(C)(iii).

ARTICLE 5

LIMITED PURPOSE SUBSIDIARY INSURANCE COMPANIES

Effective date. — This article became effective July 1, 2011.

33-14-100. Definitions.

As used in this article, the term:

(1) "Limited purpose subsidiary" means a subsidiary life, accident, and sickness reinsurer that is organized under this article and is wholly owned by an organizing domestic reinsurer.

(2) "Organizing domestic reinsurer" means a domestic life, accident, and sickness reinsurer that organizes a limited purpose subsidiary under this article.

(3) "Reinsurer" means an insurer that:

(A) Is principally engaged in the business of reinsurance;

(B) Does not conduct a significant amount of direct insurance as a percentage of the insurer's net premiums; and

(C) Is not engaged on an ongoing basis in the business of soliciting direct insurance.

(4) "Risk" means a risk that is associated with an insurance policy or annuity that is assumed by an organizing domestic reinsurer and for which the organizing domestic reinsurer is required to hold statutory reserves for the policy or annuity. (Code 1981, § 33-14-100, enacted by Ga. L. 2011, p. 446, § 1/HB 341.)

33-14-101. Authorization to organize domestic limited purpose subsidiary.

A domestic life, accident, and sickness reinsurer may organize a domestic limited purpose subsidiary pursuant to the provisions of this article. (Code 1981, § 33-14-101, enacted by Ga. L. 2011, p. 446, § 1/HB 341.)

33-14-102. Approval of operation plan and certificate of authority requirements; certain disclosure requirements; examination by Commissioner.

(a) Before assuming risk under a reinsurance agreement, a limited purpose subsidiary must:

(1) Obtain from the Commissioner approval of the limited purpose subsidiary's plan of operation; and

(2) Be granted a certificate of authority to engage in the business of reinsurance in Georgia.

(b) A limited purpose subsidiary shall produce or disclose in its plan of operation, amendments, and records, books, documents, reports, and other information that the Commissioner requires the limited purpose subsidiary to produce or disclose under:

(1) This article;

(2) Rules adopted pursuant to this article; or

(3) An order pursuant to an examination performed in accordance with the provisions of Chapter 2 of this title.

(c) The Commissioner shall examine domestic limited purpose subsidiaries pursuant to Code Section 33-2-11. (Code 1981, § 33-14-102, enacted by Ga. L. 2011, p. 446, § 1/HB 341.)

33-14-103. Powers of limited purpose subsidiary.

A limited purpose subsidiary that is granted a certificate of authority by the Commissioner under this article:

(1) Is wholly owned by the organizing domestic reinsurer;

(2) Is authorized to engage in the business of reinsurance only for the lines of insurance for which the organizing domestic reinsurer is authorized;

(3) May reinsure only risks of the organizing domestic reinsurer; and

(4) May access alternative forms of financing. (Code 1981, § 33-14-103, enacted by Ga. L. 2011, p. 446, § 1/HB 341.)

33-14-104. Investment of funds.

An organizing domestic reinsurer may invest funds from the surplus of the organizing domestic reinsurer in a limited purpose subsidiary that is organized by the organizing domestic reinsurer pursuant to this article. (Code 1981, § 33-14-104, enacted by Ga. L. 2011, p. 446, § 1/HB 341.)

33-14-105. Officers and directors.

The officers and directors of an organizing domestic reinsurer may serve as officers and directors of a limited purpose subsidiary organized by the organizing domestic reinsurer pursuant to this article. (Code 1981, § 33-14-105, enacted by Ga. L. 2011, p. 446, § 1/HB 341.)

33-14-106. Reinsurance.

A limited purpose subsidiary may, upon approval of the Commissioner, reinsure the risks assumed by the limited purpose subsidiary. (Code 1981, § 33-14-106, enacted by Ga. L. 2011, p. 446, § 1/HB 341.)

33-14-107. Assets.

(a) Assets of a limited purpose subsidiary that are approved by the Commissioner as admitted assets must comply with requirements established by the Commissioner under rules adopted pursuant to this article.

(b) All other assets shall be nonadmitted. (Code 1981, § 33-14-107, enacted by Ga. L. 2011, p. 446, § 1/HB 341.)

33-14-108. Applicability of certain Code provisions.

The following provisions of the Code do not apply to a limited purpose subsidiary organized under this article:

(1) Code Section 33-3-6;

(2) Code Section 33-3-7;

(3) Code Section 33-3-8;

(4) Code Section 33-7-14;

(5) Article 2 of Chapter 11 of this title;

(6) Code Section 33-13-4;

(7) Code Section 33-13-5;

(8) Code Section 33-14-40; and

(9) Chapter 56 of this title. (Code 1981, § 33-14-108, enacted by Ga. L. 2011, p. 446, § 1/HB 341.)

33-14-109. Adoption of rules.

(a) The Commissioner shall, before approving a limited purpose subsidiary under this article, adopt rules pursuant to Code Section 33-2-9 to implement this article.

(b) The rules adopted under subsection (a) of this Code section shall address, but not be limited to, the following concerning limited purpose subsidiaries:

(1) Requirements for organization of a limited purpose subsidiary;

(2) Requirements for a plan of operation;

(3) Capital, surplus, and risk-based capital requirements;

(4) Requirements for reporting and notifications;

(5) Requirements for reserves, including actuarial certification;

(6) Requirements for authorized investments;

(7) Requirements with respect to reinsurance ceded or assumed by the limited purpose subsidiary;

(8) Requirements and restrictions for material transactions;

(9) Requirements for dividends and distributions;

(10) Requirements for operations; and

(11) Conditions of, forms for, and approval of the financing of a limited purpose subsidiary. (Code 1981, § 33-14-109, enacted by Ga. L. 2011, p. 446, § 1/HB 341.)

CHAPTER 15

FRATERNAL BENEFIT SOCIETIES

ARTICLE 3

FORMATION AND PETITIONS FOR CHARTER; AMENDMENTS OF LAWS; REINSURANCE; CONSOLIDATIONS AND MERGERS; CONVERSIONS

33-15-40. Formation of society; petition for charter; preliminary certificate of authority; advance premiums; certificate of authority.

RESEARCH REFERENCES

Am. Jur. Pleading and Practice Forms. — 12A Am. Jur. Pleading and Practice Forms, Fraternal Orders and Benefit Societies, § 1 et seq.

ARTICLE 4

BENEFIT CONTRACTS

33-15-63. Certificate of benefits; effect of changes or additions; benefit contract binding upon children; assessment; evidentiary value; filing requirements; transfer of control of ownership; assignment.

JUDICIAL DECISIONS

Cited in Lomax v. Woodmen of World Life Ins. Soc'y, 228 F. Supp. 2d 1360 (N.D. Ga. 2002).

ARTICLE 5

ASSETS AND INVESTMENTS

33-15-83. Exemption from taxation.

Law reviews. — For survey of 2004 Eleventh Circuit cases on federal taxation, see 56 Mercer L. Rev. 1287 (2005).

CHAPTER 16

FARMERS' MUTUAL FIRE INSURANCE COMPANIES

RESEARCH REFERENCES

Am. Jur. Proof of Facts. — Fire Insurer's Bad Faith in Responding to Claim by Insured, 49 POF2d 1.

33-16-1. Scope of chapter.

Editor's notes. — Ga. L. 2012, p. 1040, § 1/SB 203, effective July 1, 2012, reenacted this Code section without change. Refer to bound volume for text of this Code section.

33-16-2. "Domestic farmers' mutual fire insurance companies" defined; risks against which companies may write insurance.

(a) "Domestic farmers' mutual fire insurance companies" are companies organized for the purpose of insuring property against loss or damage by fire, lightning, windstorm, extended coverage, and hail, and for all, or any, of such purposes.

(b) Domestic farmers' mutual fire insurance companies may write insurance against said hazards on such property risks as their charter and bylaws may provide. (Code 1933, § 56-2002, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 2012, p. 1040, § 1/SB 203.)

The 2012 amendment, effective July 1, 2012, in subsection (a), near the middle, substituted "insuring property" for "insurance on the assessment or cooperative plan", and substituted "any, of such purposes" for "either, of such purposes" at the end; and inserted "property" near the end of subsection (b).

33-16-3. Procedure for incorporation of companies generally; filing and contents of application for charter; granting of charter by Secretary of State.

(a) Twenty or more persons a majority of whom are citizens of this state may become a body corporate for the purpose of transacting insurance upon the farmers' mutual fire insurance plan as defined in Code Section 33-16-2 by making an application for a charter signed by the persons applying for the charter or their counsel in triplicate specifying:

(1) The name of the proposed corporation. The name shall contain the words "Farmers' Mutual" and shall not be so similar to any name already used by any other corporation authorized to transact business in this state as to be confusing or misleading;

(2) The purpose for which the corporation is formed;

(3) The name of the county in this state in which the corporation will have its principal office and the names of any other counties in which it proposes to operate;

(4) The name and address of each incorporator;

(5) The names and addresses of those composing the board of directors of the corporation in which the management shall be vested until the first meeting of the members; and

(6) Any other provisions not inconsistent with this chapter or other applicable laws as are deemed desirable by the incorporators or as may be required by the Commissioner.

(b) The corporate charter shall be granted by the Secretary of State as provided in Chapter 14 of this title. (Ga. L. 1923, p. 113, §§ 1-3; Ga. L. 1924, p. 122, § 1; Code 1933, §§ 56-1408, 56-1409, 56-1410, 56-1411; Code 1933, § 56-2003, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1984, p. 22, § 33; Ga. L. 2012, p. 1040, § 1/SB 203.)

The 2012 amendment, effective July 1, 2012, deleted "contiguous" preceding "counties in which" in paragraph (a)(3).

33-16-4. Issuance of certificate of authority; qualifications; proposed changes to plan of operation.

(a) No person shall transact or attempt to transact business as a farmers' mutual fire insurance company unless so authorized by a currently effective certificate of authority issued by the Commissioner.

(b) The Commissioner shall not issue or permit to exist any certificate of authority as to any insurer not currently qualified for such certificate unless it is shown to the satisfaction of the Commissioner that:

(1) The farmers' mutual fire insurance company maintains the minimum surplus required by subsection (a) of Code Section 33-16-13;

(2) The farmers' mutual fire insurance company maintains a security deposit as required by subsection (c) of Code Section 33-16-13;

(3) The farmers' mutual fire insurance company has submitted an acceptable business plan to the Commissioner that includes, but is not limited to, two-year financial projections and supporting assumptions reflecting expected premiums and losses, counties where the farmers' mutual fire insurance company intends to insure property, and the contingent liability, if any, of its members; and

(4) It must otherwise be in compliance with the requirements of this chapter.

(c) Any proposed changes to a farmers' mutual fire insurance company's plan of operation subsequent to licensure pursuant to this chapter, including but not limited to geographical expansion, shall be filed and approved in advance by the Commissioner. (Code 1933, § 56-2004, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1970, p. 165, § 1; Ga. L. 1981, p. 809, § 1; Ga. L. 1989, p. 688, § 1; Ga. L. 2012, p. 1040, § 1/SB 203.)

The 2012 amendment, effective July 1, 2012, substituted the present provisions of subsection (b) for the former provisions, which read: "(b) The Commis-

sioner shall not issue or permit to exist any certificate of authority as to any corporation or insurer not currently qualified for such certificate unless it is shown to the satisfaction of the Commissioner that:

"(1) It has received bona fide applications from not less than 25 citizens of this state for not less than $100,000.00 of insurance covering farm property located in the county or counties in which it is organized to transact business, which shall not be more than four contiguous counties and those counties which are contiguous to the county of the corporation's or insurer's domicile and with not more than the maximum amount of insurance permitted on a single risk under Code Section 33-16-14;

"(2) It has collected in cash the first payment or premium or assessment required to be paid in advance by each such applicant for its insurance according to the company's bylaws or has received from each such applicant such form of obligation, if any, as may be provided for in the bylaws to cover liability for payment of initial assessments and any future assessments as may be levied;

"(3) There is on deposit to its credit, in a bank located in the county of its domicile, funds representing a surplus of its assets over its liabilities in the amount of not less than $10,000.00; provided, however, that if such company writes an amount of insurance coverage of $7 million or more, the deposit of funds representing a surplus of its assets over its liabilities shall be an amount not less than $30,000.00;

"(4) At the time of filing the petition for a charter as required under Code Section 33-16-3, the organizers of the proposed company have filed with the Commissioner a qualified bond in the sum of $5,000.00 with good and sufficient security, subject to the Commissioner's approval. The bond shall be conditioned for the prompt return to members of all money collected from them in advance and for payment of all indebtedness of the company if the organization of the company is not completed within two years after the date of the granting of the charter; and

"(5) It must otherwise be in compliance with the requirements of this chapter."; and added subsection (c).

33-16-5. Annual license fee.

Editor's notes. — Ga. L. 2012, p. 1040, § 1/SB 203, effective July 1, 2012, reenacted this Code section without change.

Refer to bound volume for text of this Code section.

33-16-6. Board of directors generally.

Editor's notes. — Ga. L. 2012, p. 1040, § 1/SB 203, effective July 1, 2012, reenacted this Code section without change.

Refer to bound volume for text of this Code section.

33-16-7. Power of board to borrow money and pledge assets of company.

Editor's notes. — Ga. L. 2012, p. 1040, § 1/SB 203, effective July 1, 2012, reenacted this Code section without change.

Refer to bound volume for text of this Code section.

33-16-8. Contents of bylaws generally; amendment of bylaws; provision for exclusion of members.

(a) The bylaws shall state the time and manner of the levy and payment of all premiums or assessments for all insurance written by the company.

(b) The bylaws shall also fix the liability of the policyholders for all losses accrued while the policies are in force, in addition to the regular premium or assessment of the policyholders, and the time and manner of payment of such liability.

(c) The bylaws may be amended and any such amendment shall be filed with the Commissioner at least 30 days prior to its adoption.

(d) The bylaws may contain provisions for the exclusion of any member of the company who refuses or neglects to pay his or her assessment or for any other reasons satisfactory to the directors to be excluded from the insurer. (Ga. L. 1924, p. 122, § 2; Code 1933, § 56-1412; Code 1933, § 56-2008, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2000, p. 136, § 33; Ga. L. 2012, p. 1040, § 1/SB 203.)

The 2012 amendment, effective July 1, 2012, substituted "at least 30 days prior to" for "within 30 days after" in subsection (c); and inserted "or her" in subsection (d).

33-16-9. Inclusion of bylaws in insurance policy; inclusion in policy of statement of contingent liability of members.

Editor's notes. — Ga. L. 2012, p. 1040, § 1/SB 203, effective July 1, 2012, reenacted this Code section without change. Refer to bound volume for text of this Code section.

33-16-10. Inclusion in policy of provision against waiver of bylaws.

Editor's notes. — Ga. L. 2012, p. 1040, § 1/SB 203, effective July 1, 2012, reenacted this Code section without change. Refer to bound volume for text of this Code section.

33-16-11. Holding of annual and special meetings of members; notice of meetings.

An annual meeting of such company shall be held at such a time as is fixed in the bylaws of the company. Special meetings may be held for such purposes and in such manner as may be specified in the insurer's bylaws, consistent with this chapter. All such meetings shall be held in the insurer's county of domicile or other location in this state that is convenient for its membership and specified in the insurer's bylaws. Notice of such meeting shall be mailed or otherwise given to each member not less than 20 days in advance of the meeting, and notice of

any special meeting called by the board of directors shall be given in writing not less than ten days in advance stating the purpose of the meeting so called. (Code 1933, § 56-2015, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2012, p. 1040, § 1/SB 203.)

The 2012 amendment, effective July 1, 2012, added "or other location in this state that is convenient for its membership and specified in the insurer's bylaws" at the end of the third sentence in this Code section.

33-16-12. Voting by policyholders at meetings.

Each policyholder in a farmers' mutual fire insurance company shall be entitled to only one vote in all policyholders' meetings. No voting by proxy shall be permitted unless it is specially authorized in the bylaws and approved by the Commissioner. (Ga. L. 1923, p. 113, § 9; Code 1933, § 56-1416; Code 1933, § 56-2006, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2012, p. 1040, § 1/SB 203.)

The 2012 amendment, effective July 1, 2012, added "and approved by the Commissioner" at the end of this Code section.

33-16-13. Amount of minimum surplus required.

(a) The amount of minimum surplus required for each farmers' mutual fire insurance company shall be determined on an individual basis; however, no farmers' mutual fire insurance company shall be issued a certificate of authority unless it shall possess and thereafter maintain a minimum of $150,000.00 in surplus.

(b) Minimum surplus of up to $150,000.00 shall be maintained in any of the following:

(1) Cash;

(2) Certificates of deposit or similar certificates or evidence of deposits in banks or trust companies but only to the extent that the certificates or deposits are insured by the Federal Deposit Insurance Corporation; or

(3) Savings accounts, certificates of deposit, or similar certificates or evidence of deposit in savings and loan associations and building and loan associations but only to the extent that the same are insured by the Federal Savings and Loan Insurance Corporation.

(c) A portion of the minimum surplus, in an amount determined by the Commissioner, must be deposited with this state prior to the issuance of the certificate of authority. Chapter 12 of this title shall apply to the deposit required by this subsection.

(d) Any additional surplus in excess of $150,000.00 required by the Commissioner pursuant to subsection (a) of this Code section may be provided and maintained in any of the following:

(1) Any eligible investments of minimum capital or surplus authorized by Code Section 33-11-5; or

(2) Any other investments approved by the Commissioner that do not impair the financial solvency of the farmers' mutual fire insurance company. (Code 1933, § 56-2011, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1982, p. 856, § 1; Ga. L. 2012, p. 1040, § 1/SB 203.)

The 2012 amendment, effective July 1, 2012, substituted the present provisions of this Code section for the former provisions, which read: "A farmers' mutual fire insurance company shall not issue policies of insurance or otherwise insure property located in any county in this state other than the county in which it has its home office as specified in its original charter and in any other contiguous county."

33-16-14. Limitations on amounts of risks.

(a) The maximum amount of insurance that a farmers' mutual fire insurance company may retain on any subject or subjects of insurance reasonably exposed to loss from the same fire shall not exceed 10 percent of its surplus.

(b) In determining the amount at risk and retained by the insurer, any valid and applicable reinsurance authorized shall be deducted from the gross amount of risk directly assumed by the insurer. (Code 1933, § 56-2012, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1981, p. 809, § 2; Ga. L. 1986, p. 510, § 1; Ga. L. 1989, p. 688, § 2; Ga. L. 1996, p. 705, § 7; Ga. L. 2000, p. 847, § 1; Ga. L. 2012, p. 1040, § 1/SB 203.)

The 2012 amendment, effective July 1, 2012, rewrote subsection (a); deleted former subsection (b), which read: "The classification of all risks in the above schedule and the percentage given in each shall be uniformly fixed and governed by the bylaws of the insurer."; and redesignated former subsection (c) as present subsection (b).

33-16-15. Reinsurance.

Editor's notes. — Ga. L. 2012, p. 1040, § 1/SB 203, effective July 1, 2012, reenacted this Code section without change. Refer to bound volume for text of this Code section.

33-16-16. Liability of members for losses and expenses of companies.

Editor's notes. — Ga. L. 2012, p. 1040, § 1/SB 203, effective July 1, 2012, reenacted this Code section without change. Refer to bound volume for text of this Code section.

33-16-17. Actions by or against companies.

Editor's notes. — Ga. L. 2012, p. 1040, § 1/SB 203, effective July 1, 2012, reenacted this Code section without change. Refer to bound volume for text of this Code section.

33-16-18. Filing of annual statement with Commissioner.

Editor's notes. — Ga. L. 2012, p. 1040, § 1/SB 203, effective July 1, 2012, reenacted this Code section without change. Refer to bound volume for text of this Code section.

33-16-19. Examination of companies by Commissioner; payment of costs of examinations.

The Commissioner shall at least once in five years, or as often as he or she deems necessary, examine farmers' mutual fire insurance companies. The costs of the examination shall be paid by the company. (Code 1933, § 56-2018, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2012, p. 1040, § 1/SB 203.)

The 2012 amendment, effective July 1, 2012, inserted "or she" in the first sentence.

33-16-20. Exemption from taxes, costs, and fees.

Editor's notes. — Ga. L. 2012, p. 1040, § 1/SB 203, effective July 1, 2012, reenacted this Code section without change. Refer to bound volume for text of this Code section.

33-16-21. Applicability of other provisions of title to companies.

In addition to this chapter, farmers' mutual fire insurance companies shall be subject to the following chapters of this title to the extent so applicable: Chapters 1, 2, 5, 6, 12, and 37, and Article 1 of Chapter 11. (Code 1933, § 56-2022, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2012, p. 1040, § 1/SB 203.)

The 2012 amendment, effective July 1, 2012, substituted "12, and 37, and Article 1 of Chapter 11" for "and 37 of this title" in this Code section.

33-16-22. Conversion of companies into mutual insurance companies.

Editor's notes. — Ga. L. 2012, p. 1040, § 1/SB 203, effective July 1, 2012, reenacted this Code section without change. Refer to bound volume for text of this Code section.

CHAPTER 19

NONPROFIT HOSPITAL SERVICE CORPORATIONS

Law reviews. — For article, "Entity and Identity," see 60 Emory L.J. 1257 (2011).

33-19-10. Limitation as to hospitals with which corporations authorized to contract.

The corporations shall have authority to contract only with hospitals licensed by the Department of Community Health. (Code 1933, § 56-1707, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2008, p. 12, § 2-33/SB 433.)

The 2008 amendment, effective July 1, 2009, substituted "Department of Community Health" for "Department of Human Resources".

CHAPTER 20

HEALTH CARE PLANS

33-20-16. Right to become participating physician or approved health care provider.

Law reviews. — For annual survey on administrative law, see 61 Mercer L. Rev. 1 (2009).

JUDICIAL DECISIONS

Exhaustion of remedies required. — Medical group's suit for a declaratory judgment as to the group's rights to participate in a health maintenance organization under Georgia's Any Willing Provider Statute, O.C.G.A. § 33-20-16, was procedurally barred by the failure to exhaust administrative remedies by first submitting the group's dispute to the Georgia Insurance Commissioner pursuant to O.C.G.A. § 33-20-30. Northeast Ga. Cancer Care, LLC v. Blue Cross & Blue Shield of Ga., Inc., 297 Ga. App. 28, 676 S.E.2d 428 (2009), cert. denied, No. S09C1241, 2009 Ga. LEXIS 805 (Ga. 2009).

33-20-30. Resolution of disputes.

JUDICIAL DECISIONS

Exhaustion of remedies required. — Medical group's suit for a declaratory judgment as to the group's rights to participate in a health maintenance organization under Georgia's Any Willing Provider Statute, O.C.G.A. § 33-20-16, was procedurally barred by the failure to exhaust administrative remedies by first submitting the group's dispute to the Georgia Insurance Commissioner pursuant to O.C.G.A. § 33-20-30. Northeast Ga. Cancer Care, LLC v. Blue Cross & Blue Shield of Ga., Inc., 297 Ga. App. 28, 676 S.E.2d 428 (2009), cert. denied, No. S09C1241, 2009 Ga. LEXIS 805 (Ga. 2009).

33-20-34. Conversion of nonprofit health care corporation; requirements and procedures; rules and regulations.

JUDICIAL DECISIONS

Administrative review of conversion plan.

The trial court erred in deciding the merits of a proceeding seeking an interpretation of a plan of conversion because the Commissioner of Insurance had reviewed the plan, approved it, and participated in the conversion process after approval, and the parties were required to follow the administrative review process before seeking judicial review. Blue Cross & Blue Shield of Ga., Inc. v. Deal, 244 Ga. App. 700, 536 S.E.2d 590 (2000).

Review of order on plan of conversion. — The orders encompassed by § 33-2-26 include hearings to determine the propriety of plans of conversion set forth in this section. Blue Cross & Blue Shield of Ga., Inc. v. Deal, 244 Ga. App. 700, 536 S.E.2d 590 (2000).

CHAPTER 20A

MANAGED HEALTH CARE PLANS

Article 1

Patient Protection

Sec.

Article 2

Patient's Right to Independent Review

Sec.

ARTICLE 1

PATIENT PROTECTION

33-20A-3. Definitions.

As used in this article, the term:

(1) "Commissioner" means the Commissioner of Insurance.

(2) "Emergency services" or "emergency care" means those health care services that are provided for a condition of recent onset and sufficient severity, including, but not limited to, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in:

(A) Placing the patient's health in serious jeopardy;

(B) Serious impairment to bodily functions; or

(C) Serious dysfunction of any bodily organ or part.

(3) "Enrollee" means an individual who has elected to contract for or participate in a managed care plan for that individual or for that individual and that individual's eligible dependents.

(4) "Facility" means a hospital, ambulatory surgical treatment center, birthing center, diagnostic and treatment center, hospice, or similar institution for examination, diagnosis, treatment, surgery, or maternity care but does not include physicians' or dentists' private offices and treatment rooms in which such physicians or dentists primarily see, consult with, and treat patients.

(5) "Health benefit plan" has the same meaning as provided in Code Section 33-24-59.5.

(6) "Health care provider" or "provider" means any physician, dentist, podiatrist, pharmacist, optometrist, psychologist, clinical social worker, advanced practice nurse, registered optician, licensed professional counselor, physical therapist, marriage and family therapist, chiropractor, athletic trainer qualified pursuant to paragraph (1) or (2) of subsection (a) of Code Section 43-5-8, occupational therapist, speech language pathologist, audiologist, dietitian, or physician assistant.

(7) "Home health care provider" means any provider or agency that provides health care services in a patient's home including the supply of durable medical equipment for use in a patient's home.

(8) "Limited utilization incentive plan" means any compensation arrangement between the plan and a health care provider or provider group that has the effect of reducing or limiting services to patients.

(9) "Managed care contractor" means a person who:

(A) Establishes, operates, or maintains a network of participating providers;

(B) Conducts or arranges for utilization review activities; and

(C) Contracts with an insurance company, a hospital or medical service plan, an employer, an employee organization, or any other entity providing coverage for health care services to operate a managed care plan.

(10) "Managed care entity" includes an insurance company, hospital or medical service plan, hospital, health care provider network, physician hospital organization, health care provider, health maintenance organization, health care corporation, employer or employee organization, or managed care contractor that offers a managed care plan.

(11) "Managed care plan" means a major medical, hospitalization, or dental plan that provides for the financing and delivery of health care services to persons enrolled in such plan through:

(A) Arrangements with selected providers to furnish health care services;

(B) Explicit standards for the selection of participating providers; and

(C) Cost savings for persons enrolled in the plan to use the participating providers and procedures provided for by the plan; provided, however, that the term "managed care plan" does not apply to Chapter 9 of Title 34, relating to workers' compensation.

(12) "Nonurgent procedure" means any nonemergency or elective care that can be scheduled at least 24 hours prior to the service

without posing a significant threat to the patient's health or well-being.

(13) "Out of network" or "point of service" refers to health care items or services provided to an enrollee by providers who do not belong to the provider network in the managed care plan.

(14) "Patient" means a person who seeks or receives health care services under a managed care plan.

(15) "Precertification" or "preauthorization" means any written or oral determination made at any time by an insurer or any agent thereof that an enrollee's receipt of health care services is a covered benefit under the applicable plan and that any requirement of medical necessity or other requirements imposed by such plan as prerequisites for payment for such services have been satisfied. "Agent" as used in this paragraph shall not include an agent or agency as defined in Code Section 33-23-1.

(16) "Qualified managed care plan" means a managed care plan that the Commissioner certifies as meeting the requirements of this article.

(17) "Verification of benefits" means any written or oral determination by an insurer or agent thereof of whether given health care services are a covered benefit under the enrollee's health benefit plan without a determination of precertification or preauthorization as to such services. "Agent" as used in this paragraph shall not include an agent or agency as defined in Code Section 33-23-1. (Code 1981, § 33-20A-3, enacted by Ga. L. 1996, p. 485, § 1; Ga. L. 1999, p. 327, § 1; Ga. L. 1999, p. 350, § 2; Ga. L. 2002, p. 441, § 4; Ga. L. 2009, p. 859, § 3/HB 509; Ga. L. 2012, p. 775, § 33/HB 942.)

The 2002 amendment, effective July 1, 2002, inserted a comma following "including" and "to" in the introductory language of paragraph (2); redesignated former paragraph (2.1) as present paragraph (3); added paragraphs (4) and (5); redesignated former paragraph (3) as present paragraph (6); added paragraph (7); redesignated former paragraphs (4) through (7) as present paragraphs (8) through (11), respectively; added paragraph (12); redesignated former paragraphs (8) and (8.1) as present paragraphs (13) and (14), respectively; added paragraph (15); redesignated former paragraph (9) as present paragraph (16); and added paragraph (17). See Editor's notes for applicability.

The 2009 amendment, effective July 1, 2009, substituted "physician assistant" for "physician's assistant" near the end of paragraph (6).

The 2012 amendment, effective May 1, 2012, part of an Act to revise, modernize, and correct the Code, substituted "advanced practice nurse" for "advance practice nurse" in paragraph (6).

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2002, "Nonurgent" was substituted for "Non-urgent" in paragraph (12).

Editor's notes. — Ga. L. 2002, p. 441, § 1, not codified by the General Assembly, provides that: "This Act shall be known and may be cited as the 'Consumers' Health Insurance Protection Act.'"

Ga. L. 2002, p. 441, § 11, not codified by the General Assembly, provides that: "This Act shall apply only to health benefit

plan contracts issued, delivered, issued for delivery, or renewed in this state on or after October 1, 2002; provided, however, that Section 8 of this Act shall apply to all claims relating to health care services provided on or after July 1, 2002. Any carrier, plan, network, panel, or agent thereof conducting a post-payment audit or imposing a retroactive denial on any claim initially submitted prior to July 1, 2002, shall, no later than June 30, 2003, provide written notice to the claimant of the intent to conduct such an audit or impose such a retroactive denial of any such claim or part thereof, including the specific reason for the audit or denial and shall complete the audit or retroactive denial and provide notice to the claimant of any payment or refund due prior to January 1, 2004." The reference to Section 8 of the Act apparently should be to Section 9 of the Act, which enacted Article 3 of this chapter.

Law reviews. — For note on the 2002 amendment of this section, see 19 Ga. St. U. L. Rev. 220 (2002).

33-20A-5. Standards for certification.

The Commissioner shall establish standards for the certification of qualified managed care plans that conduct business in this state. Such standards must include the following provisions:

(1) **Disclosure to enrollees and prospective enrollees.**

(A) A managed care entity shall disclose to enrollees and prospective enrollees who inquire as individuals into a plan or plans offered by the managed care entity the information required by this paragraph. In the case of an employer negotiating for a health care plan or plans on behalf of his or her employees, sufficient copies of disclosure information shall be made available to employees upon request. Disclosure of information under this paragraph shall be readable, understandable, and on a standardized form containing information regarding all of the following for each plan it offers:

(i) The health care services or other benefits under the plan offered as well as limitations on services, kinds of services, benefits, or kinds of benefits to be provided, which disclosure may also be published on an Internet service site made available by the managed care entity at no cost to such enrollees;

(ii) Rules regarding copayments, prior authorization, or review requirements including, but not limited to, preauthorization review, concurrent review, postservice review, or postpayment review that could result in the patient's being denied coverage or provision of a particular service;

(iii) Potential liability for cost sharing for out-of-network services, including, but not limited to, providers, drugs, and devices or surgical procedures that are not on a list or a formulary;

(iv) The financial obligations of the enrollee, including premiums, deductibles, copayments, and maximum limits on out-of-pocket expenses for items and services (both in and out of network);

(v) The number, mix, and distribution of participating providers. An enrollee or a prospective enrollee shall be entitled to a list of individual participating providers upon request, and the list of individual participating providers shall also be updated at least every 30 days and may be published on an Internet service site made available by the managed care entity at no cost to such enrollees;

(vi) Enrollee rights and responsibilities, including an explanation of the grievance process provided under this article;

(vii) An explanation of what constitutes an emergency situation and what constitutes emergency services;

(viii) The existence of any limited utilization incentive plans;

(ix) The existence of restrictive formularies or prior approval requirements for prescription drugs. An enrollee or a prospective enrollee shall be entitled, upon request, to a description of specific drug and therapeutic class restrictions;

(x) The existence of limitations on choices of health care providers;

(xi) A statement as to where and in what manner additional information is available;

(xii) A statement that a summary of the number, nature, and outcome results of grievances filed in the previous three years shall be available for inspection. Copies of such summary shall be made available at reasonable costs; and

(xiii) A summary of any agreements or contracts between the managed care plan and any health care provider or hospital as they pertain to the provisions of Code Sections 33-20A-6 and 33-20A-7. Such summary shall not be required to include financial agreements as to actual rates, reimbursements, charges, or fees negotiated by the managed care plan and any health care provider or hospital; provided, however, that such summary may include a disclosure of the category or type of compensation, whether capitation, fee for service, per diem, discounted charge, global reimbursement payment, or otherwise, paid by the managed care plan to each class of health care provider or hospital under contract with the managed care plan.

(B) Such information shall be disclosed to each enrollee under this article at the time of enrollment and at least annually thereafter.

(C) Any managed care plan licensed under Chapter 21 of this title is deemed to have met the certification requirements of this paragraph.

(D) A managed care entity which negotiates with a primary care physician to become a health care provider under a managed care plan shall furnish that physician, beginning on and after January 1, 2001, with a schedule showing fees payable for common office based services provided by such physicians under the plan;

(2) **Access to services.** A managed care entity must demonstrate that its plan:

(A) Makes benefits available and accessible to each enrollee electing the managed care plan in the defined service area with reasonable promptness and in a manner that promotes continuity in the provision of health care services, including continuity in the provision of health care services after termination of a physician's contract as provided in Code Section 33-20A-61;

(B) When medically necessary provides health care services 24 hours a day and seven days a week;

(C) Provides payment or reimbursement for emergency services and out-of-area services; and

(D) Complies with the provisions of Code Section 33-20A-9.1 relating to nomination and reimbursement of out of network health care providers and hospitals; and

(3) **Quality assurance program.** A managed care plan shall comply with the following requirements:

(A) A managed care plan must have arrangements, established in accordance with regulations of the Commissioner, for an ongoing quality assurance program for health care service it provides to such individuals; and

(B) The quality assurance program shall:

(i) Provide for a utilization review program which, in addition to the requirements of Chapter 46 of this title:

(I) Stresses health outcomes;

(II) Provides for the establishment of written protocols for utilization review, based on current standards of the relevant health care profession;

(III) Provides review by physicians and appropriate health care providers of the process followed in the provision of such health care services;

(IV) Monitors and evaluates high volume and high risk services and the care of acute and chronic conditions;

(V) Evaluates the continuity and coordination of care that enrollees receive; and

(VI) Has mechanisms to detect both underutilization and overutilization of services; and

(ii) Establish a grievance procedure which provides the enrollee with a prompt and meaningful hearing on the issue of denial, in whole or in part, of a health care treatment or service or claim therefor. Such hearing shall be conducted by a panel of not less than three persons, at least one member of which shall be a physician other than the medical director of the plan and at least one member of which shall be a health care provider competent by reason of training and licensure in the treatment or procedure which has been denied. The enrollee shall be provided prompt notice in writing of the outcome of the grievance procedure. In the event the outcome of the grievance is favorable to the enrollee, appropriate relief shall be granted without delay. In the event the outcome is adverse to the enrollee, the notice shall include specific findings related to the care, the policies and procedures relied upon in making the determination, the physician's and provider's recommendations, including any recommendations for alternative procedures or services, and a description of the procedures, if any, for reconsideration of the adverse decision. (Code 1981, § 33-20A-5, enacted by Ga. L. 1996, p. 485, § 1; Ga. L. 1999, p. 342, § 1; Ga. L. 1999, p. 350, § 2; Ga. L. 2000, p. 802, § 1; Ga. L. 2002, p. 441, §§ 5, 8; Ga. L. 2005, p. 481, § 2/HB 291.)

The 2002 amendment, effective July 1, 2002, added subparagraph (1)(C.1) and, in subparagraph (2)(A), substituted "that" for "which" and added ", including continuity in the provision of health care services after termination of a physician's contract as provided in Code Section 33-20A-61". See Editor's notes for applicability.

The 2005 amendment, effective July 1, 2005, substituted "out-of-network" for "out of network" and inserted a comma following "including" and following "to" in division (1)(A)(iii) and deleted subparagraph (1)(C.1) which read: "Any managed care plan licensed in this state shall obtain a signed acknowledgment from each enrollee at the time of enrollment and upon any subsequent product change elected by an enrollee acknowledging that the enrollee has been informed of the following:

"(i) The number, mix, and distribution of participating providers. An enrollee shall be entitled to a list of individual participating providers and the list shall be updated at least every 30 days and may be published on an Internet service site made available by the managed care entity at no cost to such enrollee;

"(ii) The existence of limitations and disclosure of such limitations on choices of health care providers; and

"(iii) A summary of any agreements or contracts between the managed care plan and any health care provider or hospital as they pertain to the provisions of Code Sections 33-20A-6 and 33-20A-7. Such summary shall not be required to include financial agreements as to actual rates, reimbursements, charges, or fees negotiated by the managed care plan and any health care provider or hospital; provided, however, such summary may include a disclosure of the category or type of compensation, whether capitation, fee for service, per diem, discounted charge, global reimbursement payment, or otherwise, paid by the managed care plan to each class of health care provider or hospital

under contract with the managed care plan."

Editor's notes. — Ga. L. 2002, p. 441, § 1, not codified by the General Assembly, provides that: "This Act shall be known and may be cited as the 'Consumers' Health Insurance Protection Act.'"

Ga. L. 2002, p. 441, § 11, not codified by the General Assembly, provides that: "This Act shall apply only to health benefit plan contracts issued, delivered, issued for delivery, or renewed in this state on or after October 1, 2002; provided, however, that Section 8 of this Act shall apply to all claims relating to health care services provided on or after July 1, 2002. Any carrier, plan, network, panel, or agent thereof conducting a post-payment audit or imposing a retroactive denial on any claim initially submitted prior to July 1, 2002, shall, no later than June 30, 2003, provide written notice to the claimant of the intent to conduct such an audit or impose such a retroactive denial of any such claim or part thereof, including the specific reason for the audit or denial and shall complete the audit or retroactive denial and provide notice to the claimant of any payment or refund due prior to January 1, 2004." The reference to Section 8 of the Act apparently should be to Section 9 of the Act, which enacted Article 3 of this chapter.

Law reviews. — For note on the 2002 amendment of this section, see 19 Ga. St. U. L. Rev. 220 (2002).

33-20A-7.1. Application; managed care plan's liability following precertification; availability of personnel for precertification procedure.

(a)(1) The provisions of this chapter shall apply to any managed care plan offered pursuant to Article 1 of Chapter 18 of Title 45 and to any managed care plan offered by any managed care entity.

(2) When an enrollee, provider, facility, or home health care provider calls during regular business hours to request verification of benefits from a managed care plan, the caller shall have the clear and immediate option to speak to an employee or agent of such managed care plan who shall advise the caller that:

(A) Such verification is only a determination of whether given health care services are a covered benefit under the health benefit plan and is not a guarantee of payment for those services; and

(B) If the health care services so verified are a covered benefit, whether precertification is required and the phone number to request precertification.

(3) If a managed care plan provides verification of benefits after regular business hours or by electronic or recorded means, the enrollee, provider, facility, or home health care provider making the request shall be provided by either electronic or recorded means or, at the option of the insurer, by a live person the information required in subparagraphs (A) and (B) of paragraph (2) of this subsection.

(b) When an enrollee, provider, facility, or home health care provider obtains precertification for any covered health care service, the managed care plan is liable for such precertified services at the reimburse-

ment level provided under the health benefit plan for such services where rendered within the time limits set in the precertification unless the enrollee is no longer covered under the plan at the time the services are received by the enrollee, benefits under the contract or plan have been exhausted, or there exists substantiation of fraud by the enrollee, provider, facility, or home health care provider.

(c) Any managed care plan which requires precertification shall have sufficient personnel available 24 hours a day, seven days a week, to provide such precertifications for all procedures, other than nonurgent procedures; to advise of acceptance or rejection of such request for precertification; and to provide reasons for any such rejection. Such acceptance or rejection of a precertification request may be provided through a recorded or computer generated communication, provided that the individual requesting precertification has the clear and immediate option to speak to an employee or representative of the managed care plan capable of providing information about the precertification request. (Code 1981, § 33-20A-7.1, enacted by Ga. L. 2002, p. 441, § 6.)

Effective date. — This Code section became effective July 1, 2002.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2002, the introductory paragraph of subsection (a) was redesignated as paragraph (a)(1), and paragraphs (a)(1) and (a)(2) were redesignated as (a)(2) and (a)(3), respectively, in paragraph (a)(2), "paragraph (2)" was substituted for "paragraph (1)" and in subsection (c), "nonurgent" was substituted for "non-urgent".

Editor's notes. — Ga. L. 2002, p. 441, § 1, not codified by the General Assembly, provides that: "This Act shall be known and may be cited as the 'Consumers' Health Insurance Protection Act.'"

Ga. L. 2002, p. 441, § 11, not codified by the General Assembly, provides that: "This Act shall apply only to health benefit plan contracts issued, delivered, issued for delivery, or renewed in this state on or after October 1, 2002; provided, however, that Section 8 of this Act shall apply to all claims relating to health care services provided on or after July 1, 2002. Any carrier, plan, network, panel, or agent thereof conducting a post-payment audit or imposing a retroactive denial on any claim initially submitted prior to July 1, 2002, shall, no later than June 30, 2003, provide written notice to the claimant of the intent to conduct such an audit or impose such a retroactive denial of any such claim or part thereof, including the specific reason for the audit or denial and shall complete the audit or retroactive denial and provide notice to the claimant of any payment or refund due prior to January 1, 2004." The reference to Section 8 of the Act apparently should be to Section 9 of the Act, which enacted Article 3 of this chapter.

Law reviews. — For note on the 2002 enactment of this section, see 19 Ga. St. U. L. Rev. 220 (2002).

33-20A-9. Emergency services requirements; restrictive formulary requirements.

Every managed care plan shall include provisions that:

(1)(A) In the event that a patient seeks emergency services and if necessary in the opinion of the emergency health care provider responsible for the patient's emergency care and treatment and

warranted by his or her evaluation, such emergency provider may initiate necessary intervention to stabilize the condition of the patient without seeking or receiving prospective authorization by the managed care entity or managed care plan. No managed care entity or private health benefit plan may subsequently deny payment for an evaluation, diagnostic testing, or treatment provided as part of such intervention for an emergency condition. For purposes of this Code section, the term "emergency health care provider" includes without limitation an emergency services provider and a licensed ambulance service providing 911 emergency medical transportation.

(B) No managed care entity or private health benefit plan which has given prospective authorization after the stabilization of a person's condition for an evaluation, diagnostic testing, or treatment may subsequently deny payment for the provision of such evaluation, diagnostic testing, or treatment. An acknowledgment of an enrollee's eligibility for benefits by the managed care entity or private health benefit plan shall not, by itself, be construed as a prospective authorization for the purposes of this Code section.

(C) If in the opinion of the emergency health care provider, a patient's condition has stabilized and the emergency health care provider certifies that the patient can be transported to another facility without suffering detrimental consequences or aggravating the patient's condition, the patient may be relocated to another facility which will provide continued care and treatment as necessary; and

(2) When a managed care plan uses a restrictive formulary for prescription drugs, such use shall include a written procedure whereby patients can obtain, without penalty and in a timely fashion, specific drugs and medications not included in the formulary when:

(A) The formulary's equivalent has been ineffective in the treatment of the patient's disease or condition; or

(B) The formulary's drug causes or is reasonably expected to cause adverse or harmful reactions in the patient. (Code 1981, § 33-20A-9, enacted by Ga. L. 1996, p. 485, § 1; Ga. L. 1997, p. 908, § 2; Ga. L. 1999, p. 350, § 2; Ga. L. 2006, p. 652, § 3/HB 1257.)

The 2006 amendment, effective July 1, 2006, added "and a licensed ambulance service providing 911 emergency medical transportation" at the end of subparagraph (1)(A).

33-20A-9.1. Legislative intent; consumer choice option; provisions; increased expenses; covered benefits; forms.

(a) It is the intent of the General Assembly to allow citizens to have the right to choose their own health care providers and hospitals with as few mandates from government and business as possible. It is also the intent to allow these choices with minimal additional cost to any business or consumer in this state.

(b) As used in this Code section, the term "consumer choice option" means a plan for health care delivery which grants enrollees a right to receive covered services outside of any plan provider panel and under the terms and conditions of the plan.

(c) Except for managed care plans offering a consumer choice option under subparagraph (d)(2)(C) of this Code section, every managed care plan offered by a managed care entity shall offer a separate consumer choice option to enrollees at least annually with the following provisions:

(1) Every enrollee of a managed care plan shall have the right to nominate one or more out of network health care providers or hospitals for use by that enrollee and that enrollee's eligible dependents, if:

(A) Such health care provider or hospital is located within and licensed by the state;

(B) Such health care provider or hospital agrees to accept reimbursement from both the plan and the enrollee at the rates and on the terms and conditions applicable to similarly situated participating providers and hospitals. The reimbursement rates for the plan may be proportionally reduced from those paid to participating providers if the cost-sharing provisions in paragraph (3) of subsection (d) of this Code section are utilized in the consumer choice option;

(C) Such health care provider or hospital agrees to adhere to the managed care plan's quality assurance requirements and to provide the plan with necessary medical information related to such care; and

(D) Such health care provider or hospital meets all other reasonable criteria as required by the managed care plan of in network providers and hospitals; and

(2) Each nominated health care provider or hospital which meets the requirements of subparagraphs (A), (B), (C), and (D) of paragraph (1) of this subsection shall be reimbursed by the plan, subject to the agreement in subparagraph (B) of paragraph (1) of this subsection, as

though it belonged to the managed care plan's provider network. Such reimbursement shall be full and final payment for the health care services provided to the enrollee and no health care provider or hospital shall bill the enrollee for any portion of a payment exclusive of the requirements of subparagraph (B) of paragraph (1) of this subsection.

(d)(1) An enrollee who selects the consumer choice option shall be responsible for any increases in premiums and cost sharing associated with the option; provided, however, that any differential in cost sharing as provided in paragraph (3) of this subsection shall only apply when the enrollee goes out of network.

(2) Any increases in premiums for the consumer choice option shall be limited as follows:

(A) For health benefit plans offered by health maintenance organizations under Chapter 21 of this title, the managed care entity may offer both of the following options, but must offer either:

(i) The actuarial basis of the option taking into account administrative and other costs associated with the exercise of this option or a 17.5 percent increase in premium over the plan without the option, whichever is less; or

(ii) The actuarial basis of the option with cost sharing as provided under paragraph (3) of this subsection taking into account administrative and other costs associated with the exercise of this option or a 15 percent increase in premium over the plan without the option and with cost sharing as provided under paragraph (3) of this subsection, whichever is less;

(B) For all other managed care plans under this chapter, the managed care entity may offer both of the following options, but must offer either:

(i) The actuarial basis of the option taking into account administrative and other costs associated with the exercise of this option or a 10 percent increase in premium over the plan without the option, whichever is less; or

(ii) The actuarial basis of the option with cost sharing as provided under paragraph (3) of this subsection taking into account administrative and other costs associated with the exercise of this option or a 7.5 percent increase in premium over the plan without the option and with cost sharing as provided under paragraph (3) of this subsection, whichever is less;

(C) Notwithstanding subparagraph (B) of this paragraph, for all other managed care plans under this chapter, a health benefit plan

may offer at no additional premiums or cost sharing a preferred provider organization network plan under Article 2 of Chapter 30 of this title, which plan contains standards for participating providers and hospitals which:

(i) Meets the requirements of subparagraphs (A), (C), and (D) of paragraph (1) of subsection (c) of this Code section; and

(ii) Includes only health care providers and hospitals which agree to accept the reimbursement from both the plan and the enrollee at the rates and on the terms and conditions applicable to similarly situated participating providers and hospitals and under any cost-sharing conditions required of other similarly situated preferred providers, which reimbursement shall be accepted as full and final payment for the covered health care services provided to the enrollee and no preferred provider shall bill the enrollee for any portion of a payment exclusive of the requirements of this subparagraph.

Managed care plans offering the preferred provider organization network plan under this subparagraph shall not place capacity limits on the number or classes of providers authorized to be preferred providers except where the services regularly performed by a particular class of providers are not covered services within the scope of the health benefit plan or plans offered by the managed care plan pursuant to Article 2 of Chapter 30 of this title. This subparagraph shall not supersede any other requirement of this title regarding the coverage of a certain class or classes of providers.

(3) Except as provided in subparagraph (C) of paragraph (2) of this subsection for a consumer choice option without cost sharing, any increases in cost sharing for the consumer choice option, as compared to in network cost sharing, shall be limited as follows:

(A) If deductibles are used in network, any deductibles in the consumer choice option shall not exceed a 20 percent difference between in and out of network; provided, however, that deductibles cannot be accumulated separately between in network and out of network;

(B) If copayments are used in network, any copayments in the consumer choice option shall not exceed a 20 percent difference between in and out of network;

(C) In all cases, any coinsurance in the consumer choice option shall not exceed 10 percentage points difference between in and out of network; and

(D) In all cases, the maximum differential for out-of-pocket expenditures of the consumer choice option shall not exceed 20

percent as compared to in network; provided, however, that out-of-pocket expenditures cannot be accumulated separately between in network and out of network. Further, all cost sharing that is counted toward the out-of-pocket limit for the consumer choice option shall be the same as that counted toward the in network plan.

(4) After 12 months of full implementation, the pricing of the consumer choice option may be reevaluated to consider actual costs incurred and the experience of the standard plan without the option as compared to the consumer choice option. Based on an independent actuarial evaluation of such actual costs incurred and experience, managed care entities may apply for a waiver of the cost provisions of paragraphs (2) and (3) of this subsection to the Insurance Commissioner's office with copies to the consumers' insurance advocate on or after July 1, 2001.

(e) The consumer choice option shall have substantially the same covered benefits as the managed care plan without the option.

(f) For an enrollee who chooses the consumer choice option, the managed care entity shall provide such enrollee with a form to be completed by the enrollee nominated health care provider or hospital. This form shall indicate such health care provider's or hospital's agreement to accept reimbursement as provided in subparagraph (c)(1)(B) of this Code section and such health care provider's or hospital's agreement to adhere to the quality assurance requirements and other reasonable criteria of the plan as provided in subparagraphs (c)(1)(C) and (c)(1)(D) of this Code section. The form required by this subsection shall be one page, shall be signed and dated by the nominated health care provider or hospital, and shall be mailed to the managed care entity at the address indicated on the form. In a timely manner and upon receipt of such form from a nominated health care provider or hospital, the plan shall indicate acceptance of the health care provider or hospital and provide any necessary information to the health care provider or hospital including but not limited to a complete copy of the reimbursement terms, quality assurance requirements, and any other reasonable criteria required by the managed care plan of in network health care providers and hospitals. The plan may refuse to approve for reimbursement an enrollee nominated health care provider or hospital only upon a showing by clear and convincing evidence that the health care provider or hospital does not meet the requirements of paragraph (1) of subsection (c) of this Code section. (Code 1981, § 33-20A-9.1, enacted by Ga. L. 1999, p. 342, § 3; Ga. L. 2008, p. 1088, § 1/HB 1328.)

The 2008 amendment, effective July 1, 2008, deleted "offered pursuant to Article 1 of Chapter 18 of Title 45 or" following "managed care plan" in the introductory language of subsection (c).

ARTICLE 2

PATIENT'S RIGHT TO INDEPENDENT REVIEW

33-20A-30. Short title.

Editor's notes. — Ga. L. 2005, p. 1438, § 2, effective May 10, 2005, reenacted this Code section without change.

33-20A-31. Definitions.

As used in this article, the term:

(1) "Department" means the Department of Community Health established under Chapter 2 of Title 31.

(2) "Eligible enrollee" means a person who:

(A) Is an enrollee or an eligible dependent of an enrollee of a managed care plan or was an enrollee or an eligible dependent of an enrollee of such plan at the time of the request for treatment;

(B) Seeks a treatment which reasonably appears to be a covered service or benefit under the enrollee's evidence of coverage; provided, however, that this subparagraph shall not apply if the notice from a managed care plan of the outcome of the grievance procedure was that a treatment is experimental; and

(C) Is not a Medicaid care management member.

(3) "Grievance procedure" means the grievance procedure established pursuant to Code Section 33-20A-5.

(4) "Independent review organization" means any organization certified as such by the department under Code Section 33-20A-39.

(5) "Medicaid care management member" means a recipient of medical assistance, as that term is defined in paragraph (7) of Code Section 49-4-141, and shall also include a child receiving health care benefits pursuant to Article 13 of Chapter 5 of Title 49.

(6) "Medical and scientific evidence" means:

(A) Peer reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

(B) Peer reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline, and MEDLARS data base or Health Services Technology Assessment Research (HSTAR);

(C) Medical journals recognized by the United States secretary of health and human services, under Section 1861(t)(2) of the Social Security Act;

(D) The following standard reference compendia: the American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug Information; or

(E) Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, the Centers for Medicare and Medicaid Services, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services.

(7) "Medical necessity," "medically necessary care," or "medically necessary and appropriate" means care based upon generally accepted medical practices in light of conditions at the time of treatment which is:

(A) Appropriate and consistent with the diagnosis and the omission of which could adversely affect or fail to improve the eligible enrollee's condition;

(B) Compatible with the standards of acceptable medical practice in the United States;

(C) Provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms;

(D) Not provided solely for the convenience of the eligible enrollee or the convenience of the health care provider or hospital; and

(E) Not primarily custodial care, unless custodial care is a covered service or benefit under the eligible enrollee's evidence of coverage.

(8) "Treatment" means a medical service, diagnosis, procedure, therapy, drug, or device.

(9) Any term defined in Code Section 33-20A-3 shall have the meaning provided for that term in Code Section 33-20A-3 except that "enrollee" shall include the enrollee's eligible dependents. (Code 1981, § 33-20A-31, enacted by Ga. L. 1999, p. 350, § 3; Ga. L. 2002, p. 415, § 33; Ga. L. 2005, p. 1438, § 2/SB 140; Ga. L. 2006, p. 72, § 33/SB 465; Ga. L. 2009, p. 453, § 1-7/HB 228.)

The 2002 amendment, effective April 18, 2002, part of an Act to revise, modernize, and correct the Code, substituted "the Centers for Medicare and Medicaid Services" for "Health Care Financing Administration" in subparagraph (4)(E).

The 2005 amendment, effective May 10, 2005, added present paragraph (1); redesignated former paragraphs (1) through (3) as present paragraphs (2) through (4), respectively; in paragraph (2), deleted "and" at the end of subparagraph (2)(A), substituted "; and" for a period at the end of subparagraph (2)(B), and added subparagraph (2)(C); substituted "department" for "planning agency" in paragraph (4); added present paragraph (5), redesignated former paragraphs (4) and (5) as present paragraphs (6) and (7), respectively; deleted former paragraph (6) which read: "'Planning agency' means the Health Planning Agency established under Chapter 6 of Title 31 or its successor agency.", and redesignated former paragraphs (7) and (8) as present paragraphs (8) and (9), respectively.

The 2006 amendment, effective April 14, 2006, part of an Act to revise, modernize, and correct the Code, inserted ", the term" in the introductory language of this Code section.

The 2009 amendment, effective July 1, 2009, substituted "Chapter 2 of Title 31" for "Chapter 5A of Title 31" in paragraph (1).

33-20A-32. Right to appeal.

Editor's notes. — Ga. L. 2005, p. 1438, § 2, effective May 10, 2005, reenacted this Code section without change.

33-20A-33. Minimum expense of treatment prior to review.

Editor's notes. — Ga. L. 2005, p. 1438, § 2, effective May 10, 2005, reenacted this Code section without change.

33-20A-34. Representatives for enrollee; cost of review; cooperation.

Editor's notes. — Ga. L. 2005, p. 1438, § 2, effective May 10, 2005, reenacted this Code section without change.

33-20A-35. Request for independent review.

(a) In the event that the outcome of the grievance procedure under Code Section 33-20A-5 is adverse to the eligible enrollee, the managed care entity shall include with the written notice of the outcome of the grievance procedure a statement specifying that any request for independent review must be made to the department on forms developed by

the department, and such forms shall be included with the notification. Such statement shall be in simple, clear language in boldface type which is larger and bolder than any other typeface which is in the notice and in at least 14 point typeface.

(b) An eligible enrollee must submit the written request for independent review to the department. Instructions on how to request independent review shall be given to all eligible enrollees with the written notice required under this Code section together with instructions in simple, clear language as to what information, documentation, and procedure are required for independent review.

(c) Upon receipt of a completed form requesting independent review as required by subsection (a) of this Code section, the department shall notify the eligible enrollee of receipt and assign the request to an independent review organization on a rotating basis according to the date the request is received.

(d) Upon assigning a request for independent review to an independent review organization, the department shall provide written notification of the name and address of the assigned organization to both the requesting eligible enrollee and the managed care entity.

(e) No managed care entity may be certified by the Commissioner under Article 1 of this chapter unless the entity agrees to pay the costs of independent review to the independent review organization assigned by the department to conduct each review involving such entity's eligible enrollees. (Code 1981, § 33-20A-35, enacted by Ga. L. 1999, p. 350, § 3; Ga. L. 2005, p. 1438, § 2/SB 140.)

The 2005 amendment, effective May 10, 2005, substituted "department" for "planning agency" throughout this Code section.

33-20A-36. Additional information required for independent review.

(a) Within three business days of receipt of notice from the department of assignment of the application for determination to an independent review organization, the managed care entity shall submit to that organization the following:

(1) Any information submitted to the managed care entity by the eligible enrollee in support of the eligible enrollee's grievance procedure filing;

(2) A copy of the contract provisions or evidence of coverage of the managed care plan; and

(3) Any other relevant documents or information used by the managed care entity in determining the outcome of the eligible enrollee's grievance.

Upon request, the managed care entity shall provide a copy of all documents required by this subsection, except for any proprietary or privileged information, to the eligible enrollee. The eligible enrollee may provide the independent review organization with any additional information the eligible enrollee deems relevant.

(b) The independent review organization shall request any additional information required for the review from the managed care entity and the eligible enrollee within five business days of receipt of the documentation required under this Code section. Any additional information requested by the independent review organization shall be submitted within five business days of receipt of the request, or an explanation of why the additional information is not being submitted shall be provided.

(c) Additional information obtained from the eligible enrollee shall be transmitted to the managed care entity, which may determine that such additional information justifies a reconsideration of the outcome of the grievance procedure. A decision by the managed care entity to cover fully the treatment in question upon reconsideration using such additional information shall terminate independent review.

(d) The expert reviewer of the independent review organization shall make a determination within 15 business days after expiration of all time limits set forth in this Code section, but such time limits may be extended or shortened by mutual agreement between the eligible enrollee and the managed care entity. The determination shall be in writing and state the basis of the reviewer's decision. A copy of the decision shall be delivered to the managed care entity, the eligible enrollee, and the department by at least first-class mail.

(e) The independent review organization's decision shall be based upon a review of the information and documentation submitted to it.

(f) Information required or authorized to be provided pursuant to this Code section may be provided by facsimile transmission or other electronic transmission. (Code 1981, § 33-20A-36, enacted by Ga. L. 1999, p. 350, § 3; Ga. L. 2005, p. 1438, § 2/SB 140.)

The 2005 amendment, effective May 10, 2005, substituted "department" for "planning agency" in subsections (a) and (d).

33-20A-37. (Effective until January 1, 2013. See note.) Effect of favorable determinations.

Editor's notes. — Ga. L. 2005, p. 1438, § 2, effective May 10, 2005, reenacted this Code section without change.

33-20A-37. (Effective January 1, 2013. See note.) Effect of favorable determinations.

(a) A decision of the independent review organization in favor of the eligible enrollee shall be final and binding on the managed care entity and the appropriate relief shall be provided without delay. A managed care entity bound by such decision of an independent review organization shall not be liable pursuant to Code Section 51-1-48 for abiding by such decision. Nothing in this Code section shall relieve the managed care entity from liability for damages proximately caused by its determination of the proposed treatment prior to such decision.

(b) (Effective January 1, 2013. See note.) A determination by the independent review organization in favor of a managed care entity shall create a rebuttable presumption in any subsequent action that the managed care entity's prior determination was appropriate.

(c) In the event that, in the judgment of the treating health care provider, the health condition of the enrollee is such that following the provisions of Code Section 33-20A-36 would jeopardize the life or health of the eligible enrollee or the eligible enrollee's ability to regain maximum function, as determined by the treating health care provider, an expedited review shall be available. The expedited review process shall encompass all elements enumerated in Code Sections 33-20A-36 and 33-20A-40; provided, however, that a decision by the expert reviewer shall be rendered within 72 hours after the expert reviewer's receipt of all available requested documents. (Code 1981, § 33-20A-37, enacted by Ga. L. 1999, p. 350, § 3; Ga. L. 2005, p. 1438, § 2/SB 140; Ga. L. 2011, p. 99, § 46/HB 24.)

Delayed effective date. — This Code section, as set forth above, is effective on January 1, 2013. For the version of this Code section effective until that date, see the bound volume.

The 2011 amendment, effective January 1, 2013, deleted "and shall constitute a medical record for purposes of Code Section 24-7-8" following "appropriate" at the end of subsection (b). See editor's note for applicability.

Editor's notes. — Ga. L. 2011, p. 99, § 101, not codified by the General Assembly, provides that the amendment to this Code section by that Act shall apply to any motion made or hearing or trial commenced on or after January 1, 2013.

Law reviews. — For article, "Evidence," see 27 Ga. St. U. L. Rev. 1 (2011). For article on the 2011 amendment of this Code section, see 28 Ga. St. U. L. Rev. 1 (2011).

33-20A-38. Organizational and employee liability.

Editor's notes. — Ga. L. 2005, p. 1438, § 2, effective May 10, 2005, reenacted this Code section without change.

33-20A-39. Certification of independent review organizations; conflict of interest; quality assurance mechanism; copies of nonproprietary information.

(a) The department shall certify independent review organizations that meet the requirements of this Code section and any regulations promulgated by the department consistent with this article. The department shall deem certified any independent review organization meeting standards developed for this purpose by an independent national accrediting organization. To qualify for certification, an independent review organization must show the following:

(1) Expert reviewers assigned by the independent review organization must be physicians or other appropriate providers who meet the following minimum requirements:

(A) Are expert in the treatment of the medical condition at issue and are knowledgeable about the recommended treatment through actual clinical experience;

(B) Hold a nonrestricted license issued by a state of the United States and, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of review; and

(C) Have no history of disciplinary action or sanctions, including, but not limited to, loss of staff privileges or participation restriction, taken or pending by any hospital, government, or regulatory body;

(2) The independent review organization shall not be a subsidiary of, nor in any way owned or controlled by, a health plan, a trade association of health plans, a managed care entity, or a professional association of health care providers; and

(3) The independent review organization shall submit to the department the following information upon initial application for certification, and thereafter within 30 days of any change to any of the following information:

(A) The names of all owners of more than 5 percent of any stock or options, if a publicly held organization;

(B) The names of all holders of bonds or notes in excess of $100,000.00, if any;

(C) The names of all corporations and organizations that the independent review organization controls or is affiliated with, and the nature and extent of any ownership or control, including the affiliated organization's type of business; and

(D) The names of all directors, officers, and executives of the independent review organization, as well as a statement regarding any relationships the directors, officers, and executives may have with any health care service plan, disability insurer, managed care entity or organization, provider group, or board or committee.

(b) Neither the independent review organization nor any expert reviewer of the independent review organization may have any material professional, familial, or financial conflict of interest with any of the following:

(1) A managed care plan or entity being reviewed;

(2) Any officer, director, or management employee of a managed care plan which is being reviewed;

(3) The physician, the physician's medical group, health care provider, or the independent practice association proposing a treatment under review;

(4) The institution at which a proposed treatment would be provided;

(5) The eligible enrollee or the eligible enrollee's representative; or

(6) The development or manufacture of the treatment proposed for the eligible enrollee whose treatment is under review.

(c) As used in subsection (b) of this Code section, the term "conflict of interest" shall not be interpreted to include a contract under which an academic medical center or other similar medical research center provides health care services to eligible enrollees of a managed care plan, except as subject to the requirement of paragraph (4) of subsection (b) of this Code section; affiliations which are limited to staff privileges at a health care facility; or an expert reviewer's participation as a contracting plan provider where the expert is affiliated with an academic medical center or other similar medical research center that is acting as an independent review organization under this article. An agreement to provide independent review for an eligible enrollee or managed care entity is not a conflict of interest under subsection (b) of this Code section.

(d) The independent review organization shall have a quality assurance mechanism in place that ensures the timeliness and quality of the reviews, the qualifications and independence of the experts, and the confidentiality of medical records and review materials.

(e) The department shall provide upon the request of any interested person a copy of all nonproprietary information filed with it pursuant to this article. The department shall provide at least quarterly a current list of certified independent review organizations to all managed care

entities and to any interested persons. (Code 1981, § 33-20A-39, enacted by Ga. L. 1999, p. 350, § 3; Ga. L. 2005, p. 1438, § 2/SB 140.)

The 2005 amendment, effective May 10, 2005, substituted "department" for "planning agency" six times in subsections (a) and (e).

33-20A-40. Determining medical necessity or whether a treatment is experimental.

(a) For the purposes of this article, in making a determination as to whether a treatment is medically necessary and appropriate, the expert reviewer shall use the definition provided in paragraph (7) of Code Section 33-20A-31.

(b) For the purposes of this article, in making a determination as to whether a treatment is experimental, the expert reviewer shall determine:

(1) Whether such treatment has been approved by the federal Food and Drug Administration; or

(2) Whether medical and scientific evidence demonstrates that the expected benefits of the proposed treatment would be greater than the benefits of any available standard treatment and that the adverse risks of the proposed treatment will not be substantially increased over those of standard treatments.

For either determination, the expert reviewer shall apply prudent professional practices and shall assure that at least two documents of medical and scientific evidence support the decision. (Code 1981, § 33-20A-40, enacted by Ga. L. 1999, p. 350, § 3; Ga. L. 2005, p. 1438, § 2/SB 140.)

The 2005 amendment, effective May 10, 2005, substituted "paragraph (7)" for "paragraph (5)" in subsection (a).

33-20A-41. Rules and regulations.

The department shall provide necessary rules and regulations for the implementation and operation of this article. (Code 1981, § 33-20A-41, enacted by Ga. L. 1999, p. 350, § 3; Ga. L. 2005, p. 1438, § 2/SB 140.)

The 2005 amendment, effective May 10, 2005, substituted "department" for "planning agency".

33-20A-42. Grievance procedures and hearings for Medicaid care management members.

Medicaid care management members shall, after first exhausting the grievance procedure of the managed care plan providing health care benefits pursuant to Article 7 of Chapter 4 of Title 49 or Article 13 of Chapter 5 of Title 49, be afforded the fair hearing rights provided pursuant to Code Section 49-4-153 or the state plan provided for in Article 13 of Chapter 5 of Title 49. (Code 1981, § 33-20A-42, enacted by Ga. L. 2005, p. 1438, § 2/SB 140.)

Effective date. — This Code section became effective May 10, 2005.

ARTICLE 3

MANAGED HEALTH CARE PLANS

Effective date. — This article became effective July 1, 2002.

Editor's notes. — Ga. L. 2002, p. 441, § 1, not codified by the General Assembly, provides that: "This Act shall be known and may be cited as the 'Consumers' Health Insurance Protection Act.'"

Ga. L. 2002, p. 441, § 11, not codified by the General Assembly, provides that: "This Act shall apply only to health benefit plan contracts issued, delivered, issued for delivery, or renewed in this state on or after October 1, 2002; provided, however, that Section 8 of this Act shall apply to all claims relating to health care services provided on or after July 1, 2002. Any carrier, plan, network, panel, or agent thereof conducting a post-payment audit or imposing a retroactive denial on any claim initially submitted prior to July 1, 2002, shall, no later than June 30, 2003, provide written notice to the claimant of the intent to conduct such an audit or impose such a retroactive denial of any such claim or part thereof, including the specific reason for the audit or denial and shall complete the audit or retroactive denial and provide notice to the claimant of any payment or refund due prior to January 1, 2004." The reference to Section 8 of the Act apparently should be to Section 9 of the Act, which enacted Article 3 of this chapter.

33-20A-60. Definitions.

As used in this article, the term:

(1) "Agent" as used in this article shall not include an agent or agency as defined in Code Section 33-23-1.

(2) "Carrier" means an accident and sickness insurer, fraternal benefit society, hospital service corporation, medical service corporation, health care corporation, health maintenance organization, provider sponsored health care corporation, or any similar entity and any self-insured health benefit plan not subject to the exclusive jurisdiction of the federal Employee Retirement Income Security Act of 1974, 29 U.S.C. Section 1001, et seq., which entity provides for the financing or delivery of health care services through a health benefit

plan, or the plan administrator of any health benefit plan established pursuant to Article 1 of Chapter 18 of Title 45.

(3) "Claimant" means any provider, facility, or individual making a claim under a health benefit plan on behalf of an enrollee.

(4) "Commissioner" means the Commissioner of Insurance.

(5) "Enrollee" has the same meaning as provided in Code Section 33-20A-3.

(6) "Health benefit plan" has the same meaning as provided in Code Section 33-24-59.5.

(7) "Physician contract" means any contract between a physician and a carrier or a carrier's network, physician panel, intermediary, or representative providing the terms under which the physician agrees to provide health care services to an enrollee pursuant to a health benefit plan.

(8) "Postpayment audit" means an investigation by a health benefit plan, carrier, insurer, or panel, or agent thereof, of whether a claim was properly paid to a claimant.

(9) "Retroactive denial of a previously paid claim" or "retroactive denial of payment" means any attempt by a carrier retroactively to collect payments already made to a claimant with respect to a claim, or any portion thereof, by requiring repayment of such payments, by reducing other payments currently owed to the claimant, by withholding or setting off against future payments, or in any other manner reducing or affecting the future claim payments to the claimant. (Code 1981, § 33-20A-60, enacted by Ga. L. 2002, p. 441, § 9; Ga. L. 2003, p. 140, § 33.)

The 2003 amendment, effective May 14, 2003, part of an Act to revise, modernize, and correct the Code, redesignated paragraphs (1) through (8) as present paragraphs (2) through (9), respectively, substituted "postpayment" for "post-payment" in present paragraph (8), and added paragraph (1).

Editor's notes. — For short title and applicability, see the Editor's note at the beginning of this article.

Law reviews. — For note on the 2002 amendment of this section, see 19 Ga. St. U. L. Rev. 220 (2002).

33-20A-61. Physician contracts.

(a) Every physician contract entered into, amended, extended, or renewed after July 1, 2002, by a carrier shall contain a specific provision which shall provide that, in the event that an insurance carrier, plan, network, panel, or any agent thereof should terminate a physician's contract and thereby affect any enrollee's opportunity to continue receiving health care services from that physician under the

plan, any such enrollee who is suffering from and receiving active health care services for a chronic or terminal illness or who is an inpatient shall have the right to continue to receive health care services from that physician for a period of up to 60 days from the date of the termination of the physician's contract. Any enrollee who is pregnant and receiving treatment in connection with that pregnancy at the time of the termination of that enrollee's physician's contract shall have the right to continue receiving health care services from that physician throughout the remainder of that pregnancy, including six weeks' postdelivery care. During such continuation of coverage period, the physician shall continue providing such services in accordance with the terms of the contract applicable at the time of the termination, and the carrier, plan, network, panel, and all agents thereof shall continue to meet all obligations of such physician's contract. The enrollee shall not have the right to the continuation provisions provided in this Code section if the physician's contract is terminated because of the suspension or revocation of the physician's license or if the carrier, plan, network, panel, or any agent thereof determines that the physician poses a threat to the health, safety, or welfare of enrollees.

(b) Every physician contract entered into, amended, extended, or renewed after July 1, 2002, by a carrier shall contain a specific provision which shall provide that, in the event that a physician should terminate his or her contract with an insurance carrier, plan, network, panel, or any agent thereof and thereby affect any enrollee's opportunity to continue receiving health care services from that physician under the plan, any such enrollee who is suffering from and receiving active health care services for a chronic or terminal illness or who is an inpatient shall have the right to receive health care services from that physician for a period of up to 60 days from the date of the termination of the physician's contract. Any enrollee who is pregnant and receiving health care services in connection with that pregnancy at the time of the termination of that enrollee's physician's contract shall have the right to continue receiving health care services from that physician throughout the remainder of that pregnancy, including six weeks' postdelivery care. During such continuation of coverage period, the physician shall continue providing such services in accordance with the terms of the contract applicable at the time of the termination, and the carrier, plan, network, panel, and all agents thereof shall continue to meet all obligations of such physician's contract. The enrollee shall not have the right to the continuation provisions provided in this Code section if the physician terminates his or her contract because of the suspension or revocation of the physician's license or for reasons related to the quality of health care services rendered or issues related to the health, safety, or welfare of enrollees. (Code 1981, § 33-20A-61, enacted by Ga. L. 2002, p. 441, § 9.)

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2002, "six weeks'" was substituted for "six-weeks" in subsections (a) and (b).

Editor's notes. — For short title and applicability, see the Editor's note at the beginning of this article.

33-20A-62. Payment.

(a) No carrier, plan, network, panel, or any agent thereof may conduct a postpayment audit or impose a retroactive denial of payment on any claim by any claimant relating to the provision of health care services that was submitted within 90 days of the last date of service or discharge covered by such claim unless:

(1) The carrier, plan, network, panel, or agent thereof has provided to the claimant in writing notice of the intent to conduct such an audit or impose such a retroactive denial of payment of such claim or any part thereof and has provided in such notice the specific claim and the specific reason for the audit or retroactive denial of payment;

(2) Not more than 12 months have elapsed since the last date of service or discharge covered by the claim prior to the delivery to the claimant of such written notice; and

(3) Any such audit or retroactive denial of payment must be completed and notice provided to the claimant of any payment or refund due within 18 months of the last date of service or discharge covered by such claim.

(b) No carrier, plan, network, panel, or any agent thereof may conduct a postpayment audit or impose a retroactive denial of payment on any claim by any claimant relating to the provision of health care services that was submitted more than 90 days after the last date of service or discharge covered by such claim unless:

(1) The carrier, plan, network, panel, or agent thereof has provided to the claimant in writing notice of the intent to conduct such an audit or impose such a retroactive denial of payment of such claim or any part thereof and has provided in such notice the specific claim and the specific reason for the audit or retroactive denial of payment;

(2) Not more than 12 months have elapsed since such claim was initially submitted by the claimant prior to the delivery to the claimant of such written notice; and

(3) Any such audit or retroactive denial of payment must be completed and notice provided to the claimant of any payment or refund due within the sooner of 18 months after the claimant's initial submission of such a claim or 24 months after the date of service.

(c) No carrier, plan, network, panel, or any agent thereof shall be required to respond to a provider or facility's request for additional

payment or to adjust any previously paid provider or facility's claim or any part thereof following a final payment unless:

(1) The provider or facility makes a request in writing to the carrier, plan, network, panel, or any agent thereof specifically identifying the previously paid claim or any part thereof and provides the specific reason for additional payment; and

(2) If the provider or facility's claim was submitted within 90 days of the last date of service or discharge covered by such claim, the written request for additional payment or adjustment must be submitted within the earlier of 12 months of the date both the provider or facility and the insurer, network, panel, plan, or carrier or any agent thereof agree that all payments relative to the claim have been made and all appeals of such determinations have been made or waived by the provider or facility or 24 months have elapsed from the date of service or discharge.

(d) No carrier, plan, network, panel, or any agent thereof shall be required to respond to a provider or facility's request for additional payment or to adjust any previously paid provider or facility's claim or any part thereof following a final payment unless:

(1) The provider or facility makes a request in writing to the carrier, plan, network, panel, or any agent thereof specifically identifying the previously paid claim or any part thereof and provides the specific reason for additional payment; and

(2) If the provider or facility's claim was submitted more than 90 days after the last date of service or discharge covered by such claim, the written request for additional payment or adjustment must be submitted within the earlier of six months of the date both the provider or facility and the insurer, network, panel, plan, or carrier or any agent thereof agree that all payments relative to the claim have been made and all appeals of such determinations have been made or waived by the provider or facility or 24 months have elapsed from the date of service or discharge.

(e) An enrollee who is not billed for services by any provider, facility, or agent thereof within 45 days of the date that the provider, facility, or agent thereof knew that further payment was due as the result of a postpayment audit, retroactive denial, or rejected request to adjust a previously paid claim shall be relieved of any and all legal obligations to respond to a request for additional payment.

(f) Notwithstanding any other provision in this article to the contrary, when precertification has been obtained for a service, the insurer, carrier, plan, network, panel, or agent thereof shall be prohibited from contesting, requesting payment, or reopening such claim or any portion

thereof at any time following precertification except to the extent the insurer is not liable for the payment under Code Section 33-20A-7.1.

(g) Nothing in this article shall be construed as prohibiting reimbursement subject to Code Section 33-24-56.1. (Code 1981, § 33-20A-62, enacted by Ga. L. 2002, p. 441, § 9; Ga. L. 2003, p. 140, § 33.)

The 2003 amendment, effective May 14, 2003, part of an Act to revise, modernize, and correct the Code, revised punctuation in subsections (a), (b), and (e), and deleted former subsection (h) which read: "'Agent' as used in this article shall not include an agent or agency as defined in Code Section 33-23-1."

Editor's notes. — For short title and applicability, see the Editor's note at the beginning of this article.

ARTICLE 4

JOINT COMMITTEE TO STUDY PRESCRIPTION COSTS IN STATE FUNDED HEALTH CARE PLANS

33-20A-70. Creation; members; meetings; duties; cooperation by the Department of Community Health; members' expenses; repealer.

Repealed by Ga. L. 2005, p. 1438, § 1/SB 140, effective December 31, 2005.

Editor's notes. — This article was based on Code 1981, § 33-20A-70, enacted by Ga. L. 2005, p. 1438, § 1/SB 140.

CHAPTER 20B

ESSENTIAL RURAL HEALTH CARE PROVIDER ACCESS

Sec.
33-20B-2. Definitions.
33-20B-3.1. Health maintenance organizations' expansion into rural areas.

33-20B-2. Definitions.

As used in this chapter, the term:

(1) "Essential rural health care provider" means any hospital, federally qualified health center, or rural health clinic, as such terms are defined in this Code section, which is located in a rural area and which complies with the provisions of Code Section 33-20B-3.

(2) "Federally qualified health center" means, for the purposes of this Code section, a facility which meets the definition of a federally qualified health center as described in Section 1395x(aa)(4) of Title 42 of the United States Code Annotated and which is located in a rural area.

(3) "Health benefit plan" or "plan" means the health insurance policy or subscriber agreement between a covered person or policyholder and a health care insurer which defines the covered services and benefit levels available.

(4) "Health care insurer" means an insurer, a fraternal benefit society, a health care plan, a nonprofit medical service corporation, a nonprofit hospital service corporation, a health care corporation, a health maintenance organization, or any other entity authorized to sell accident and sickness insurance policies, subscriber certificates, or other contracts of health insurance by whatever name called under this title.

(5) "Health care services" means services rendered or products sold by an essential rural health care provider within the scope of such provider's license or legal authorization.

(6) "Hospital" means any building or facility licensed by the department as a hospital under this chapter which:

(A) Operates no more than 100 beds;

(B) Provides 24 hour emergency care as well as a range of health care services sufficient to support the practice of a primary care physician; and

(C) For at least one of the immediately preceding two fiscal years, derived at least 40 percent of its patient revenues from medicare, Medicaid, or any combination of medicare and Medicaid.

(7) "Physician" for purposes of this Code section only means any person who is licensed to practice medicine by the Georgia Composite Medical Board pursuant to Chapter 34 of Title 43 who practices as a family physician, general internist, pediatrician, general practitioner, general surgeon, or obstetrician/gynecologist and who has medical staff privileges at a hospital as defined in paragraph (6) of this Code section.

(8) "Rural area" means any county having a population of less than 35,000 according to the United States decennial census of 1990 or any future such census.

(9) "Rural health clinic" means a facility which is located in a rural area and which meets the definition of a rural health clinic as described in Section 1395x(aa)(2) of Title 42 of the United States Code

Annotated. (Code 1981, § 33-20B-2, enacted by Ga. L. 1998, p. 900, § 2; Ga. L. 1999, p. 81, § 33; Ga. L. 2009, p. 859, § 2/HB 509.)

The 2009 amendment, effective July 1, 2009, substituted "Georgia Composite Medical Board" for "Composite State Board of Medical Examiners" near the middle of paragraph (7).

33-20B-3. Qualifications for participating providers; reasonable consideration.

Law reviews. — For note on 2000 amendment of O.C.G.A. § 33-20B-3, see 17 Ga. St. U. L. Rev. 215 (2000).

33-20B-3.1. Health maintenance organizations' expansion into rural areas.

When reviewing a health maintenance organization's request to originate or expand an area of service into a rural area, the commissioner of community health shall consider whether the health maintenance organization has demonstrated its willingness to grant reasonable consideration to essential rural health care providers in the negotiating and contracting process. (Code 1981, § 33-20B-3.1, enacted by Ga. L. 2000, p. 439, § 1; Ga. L. 2009, p. 453, § 1-6/HB 228.)

The 2009 amendment, effective July 1, 2009, substituted "commissioner of community health" for "commissioner of human resources" in this Code section.

Law reviews. — For note on 2000 enactment of O.C.G.A. § 33-20B-3.1, see 17 Ga. St. U. L. Rev. 215 (2000).

CHAPTER 21

HEALTH MAINTENANCE ORGANIZATIONS

RESEARCH REFERENCES

Am. Jur. Proof of Facts. — Liability of Health Maintenance Organizations, 66 POF3d 1.

33-21-3. Grounds and procedure for issuance or denial of certificate of authority; endorsement of change of address upon certificate of authority.

(a) Upon receipt of an application for issuance of a certificate of authority, the Commissioner of Insurance shall forthwith transmit copies of such application and accompanying documents to the commissioner of community health; provided, however, that if the applicant meets the standards of subsection (b.1) of this Code section the Commissioner shall not be required to transmit the application and accompanying documents to the commissioner of community health.

(b) The commissioner of community health shall determine whether the applicant for a certificate of authority, with respect to health care services to be furnished:

(1) Has demonstrated the willingness and potential ability to assure that such health care services will be provided in a manner to assure both availability and accessibility of adequate personnel and facilities and in a manner enhancing availability, accessibility, and continuity of service;

(2) Has arrangements, established in accordance with existing laws and regulations promulgated by the commissioner of community health, for an ongoing quality of health care assurance program concerning health care processes and outcomes;

(3) Has a procedure, established in accordance with regulations of the commissioner of community health, to develop, compile, evaluate, and report statistics relating to the cost of its operations, the pattern of utilization of its services, the availability and accessibility of its services, and such other matters as may be reasonably required by the commissioner of community health;

(4) Has arrangements, established in accordance with existing laws and regulations promulgated by the commissioner of community

health, for coverage of out-of-area emergency services rendered to its enrollees; and

(5) Has arrangements to comply with the provisions of Code Section 33-20A-9.1, relating to nomination and reimbursement of providers which are not on that health maintenance organization's provider panel.

(b.1) An applicant that is compliant with or accredited by a nationally recognized accreditation agency or organization shall be deemed to be in compliance with subsection (b) of this Code section; and, upon submission of proof of compliance or accreditation to the Commissioner of Insurance, certification pursuant to subsection (c) of this Code section shall not be required. The Commissioner of Insurance shall be authorized to promulgate rules and regulations to determine which national accreditation agencies shall be used for purposes of this Code section.

(c) Within 90 days of receipt of the application for issuance of a certificate of authority, the commissioner of community health shall certify to the Commissioner of Insurance whether the proposed health maintenance organization meets the requirements of subsection (b) of this Code section. If the commissioner of community health certifies that the health maintenance organization does not meet the requirements, he or she shall specify in what respects it is deficient.

(d) The Commissioner of Insurance shall issue or deny a certificate of authority to any person filing an application pursuant to Code Section 33-21-2 within 90 days of receipt of the certification from the commissioner of community health or upon the applicant's presentation of proof to the Commissioner of Insurance of its compliance with or accreditation by a national accreditation agency or organization. Issuance of a certificate of authority shall be granted upon payment of the application fees prescribed in Code Sections 33-8-1 and 33-8-3 if the Commissioner of Insurance is satisfied that the following conditions are met:

(1) The persons responsible for the conduct of the affairs of the applicant are competent and trustworthy, possess good reputations, and have had appropriate administrative experience, training, or education in health care delivery systems or allied professions;

(2) The commissioner of community health certifies, in accordance with subsection (a) of this Code section, that the health maintenance organization's proposed plan of operation meets the requirements of subsection (b) of this Code section or the Commissioner of Insurance has received proof of the health maintenance organization's compliance with or accreditation by a nationally recognized accreditation agency or organization;

(3) The health benefits plan constitutes an appropriate mechanism whereby the health maintenance organization will effectively provide

or arrange for the provision of basic health care services on a prepaid basis, through insurance or otherwise, except to the extent of reasonable requirements for copayments;

(4) The health maintenance organization is financially responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees. In making this determination, the Commissioner of Insurance may consider:

(A) The financial soundness of the health benefits plan's arrangements for health care services and the schedule or charges used in connection with providing health care services;

(B) The adequacy of working capital;

(C) Any agreement with an insurer, a government, or any other organization for insuring the payment of the cost of health care services or the provision for automatic applicability of an alternative coverage in the event of discontinuance of the plan;

(D) Any agreement with providers for the provision of health care services; and

(E) Any deposit of cash or securities submitted in accordance with Code Section 33-21-10 as a guarantee that the obligations will be duly performed;

(5) The enrollees will be afforded an opportunity to participate in matters of policy and operation pursuant to Code Section 33-21-6;

(6) Nothing in the proposed method of operation, as shown by the information submitted pursuant to Code Section 33-21-2 or by independent investigation, is contrary to the public interest; and

(7) Any deficiencies, if applicable, certified by the commissioner of community health have been corrected.

(e) Before any health maintenance organization changes its address, the certificate of authority shall be returned to the Commissioner of Insurance who shall endorse the certificate of authority indicating the change. (Code 1933, § 56-3603, enacted by Ga. L. 1979, p. 1148, § 1; Ga. L. 1986, p. 676, § 4; Ga. L. 1999, p. 342, § 4; Ga. L. 2004, p. 493, § 1; Ga. L. 2005, p. 60, § 33/HB 95; Ga. L. 2009, p. 453, § 1-6/HB 228.)

The 2004 amendment, effective May 13, 2004, added the proviso at the end of subsection (a); added subsection (b.1); and, in subsection (d), added "or upon the applicant's presentation of proof to the Commissioner of Insurance of its compliance with or accreditation by a national accreditation agency or organization" at the end of the first sentence, substituted "and" for a comma near the beginning of paragraph (d)(1), and added "or the Commissioner of Insurance has received proof of the health maintenance organization's compliance with or accreditation by a nationally recognized accreditation agency or organization" at the end of paragraph (d)(2), and inserted ", if applicable," at the beginning of paragraph (d)(7).

The 2005 amendment, effective April 7, 2005, part of an Act to revise, modernize, and correct the Code, revised punctuation in subsection (a).

The 2009 amendment, effective July 1, 2009, substituted "commissioner of community health" for "commissioner of human resources" throughout this Code section.

33-21-5. Suspension or revocation of certificate of authority.

(a) The Commissioner of Insurance may suspend or revoke any certificate of authority issued to a health maintenance organization under this chapter if he finds that any of the following conditions exist:

(1) The health maintenance organization is operating significantly in contravention of its basic organizational document, its health benefits plan, or in a manner contrary to that described in and reasonably inferred from any other information submitted under Code Section 33-21-2, unless amendments to the submissions have been filed with and approved by the Commissioner of Insurance;

(2) The health maintenance organization issues evidence of coverage or uses a schedule of charges for health care services which do not comply with the requirements of Code Section 33-21-13;

(3) The health benefits plan does not provide or arrange for basic health care services;

(4) The health maintenance organization does not meet the requirements of Code Section 33-21-3 or is unable to fulfill its obligations to furnish health care services as required under its health benefits plan;

(5) The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

(6) The health maintenance organization has failed to implement a mechanism affording the enrollees an opportunity to participate in matters of policy and operation under Code Section 33-21-6;

(7) The health maintenance organization has failed to implement the complaint system required by Code Section 33-21-9 in a manner to resolve valid complaints reasonably;

(8) The health maintenance organization, or any person on its behalf, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive, or unfair manner;

(9) The continued operation of the health maintenance organization would be hazardous to its enrollees; or

(10) The health maintenance organization has violated any provision of this chapter or of the rules and regulations of the Commis-

sioner of Insurance or of the rules and regulations of the commissioner of community health; provided, however, that health maintenance organizations meeting the requirements of subsection (b.1) of Code Section 33-21-3 shall not be subject to the rules and regulations of the commissioner of community health.

(b) The Commissioner of Insurance may, without advance notice or a hearing thereon, suspend immediately the certificate of authority of any health maintenance organization as to which proceedings for receivership, conservatorship, rehabilitation, or other delinquency proceedings have been commenced in any state.

(c) When the certificate of authority of a health maintenance organization is suspended, the health maintenance organization shall not, during the period of the suspension, enroll any additional enrollees except newborn children or other newly acquired dependents of existing enrollees and shall not engage in any advertising or solicitation whatsoever.

(d) When the certificate of authority of a health maintenance organization is revoked, such organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of such organization. It shall engage in no further advertising or solicitation whatsoever. The Commissioner of Insurance may, by written order, permit such further operation of the organization as he may find to be in the best interest of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing health care coverage. (Code 1933, § 56-3617, enacted by Ga. L. 1979, p. 1148, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 1992, p. 6, § 33; Ga. L. 2004, p. 493, § 2; Ga. L. 2009, p. 453, § 1-6/HB 228.)

The 2004 amendment, effective May 13, 2004, rewrote paragraph (a)(4) and added the proviso at the end of paragraph (a)(10).

The 2009 amendment, effective July 1, 2009, substituted "commissioner of community health" for "commissioner of human resources" twice in paragraph (a)(10).

33-21-9. Establishment and maintenance of complaint system; maintenance of records of complaints; summary reports; examination of system.

(a) Every health maintenance organization shall establish and maintain a complaint system which has been approved by the Commissioner of Insurance to provide reasonable procedures for the resolution of written complaints initiated by enrollees or providers concerning health care services.

(b) The health maintenance organization shall maintain records of written complaints concerning health care services for five years from the time the complaints are filed and shall submit to the Commissioner of Insurance a summary report at such times and in such format as the Commissioner of Insurance may require.

(c) The Commissioner of Insurance may examine the complaint system at any time. (Code 1933, § 56-3610, enacted by Ga. L. 1979, p. 1148, § 1; Ga. L. 1986, p. 676, § 7; Ga. L. 2004, p. 493, § 3.)

The 2004 amendment, effective May 13, 2004, deleted "after consultation with the Commissioner of Human Resources" preceding "to provide" in the middle of subsection (a) and deleted "or the Commissioner of Human Resources" preceding "may examine" at the beginning of subsection (c).

33-21-15. Filing of annual reports; contents.

(a) Every health maintenance organization shall annually, on or before March 1, file with the Commissioner of Insurance, on forms to be designated by him and certified by at least two principal officers of said health maintenance organization, an annual statement as of December 31 of the preceding year and a copy of said report shall also be delivered to the commissioner of community health.

(b) Such report shall be on forms prescribed by the Commissioner of Insurance and shall include:

(1) A financial statement of the organization, including its balance sheet and receipts and disbursements for the preceding year certified by an independent public accountant;

(2) Any material changes in the information submitted pursuant to subsection (b) of Code Section 33-21-2;

(3) The number of persons enrolled during the year, the number of enrollees as of the end of the year, and the number of enrollments terminated during the year;

(4) A summary of information compiled pursuant to paragraph (3) of subsection (b) of Code Section 33-21-3 in such form as required by the commissioner of community health; and

(5) Any other information relating to the financial condition or performance of the health maintenance organization as is necessary to enable the Commissioner of Insurance and the commissioner of community health to carry out their duties under this chapter. (Code 1933, § 56-3608, enacted by Ga. L. 1979, p. 1148, § 1; Ga. L. 1992, p. 6, § 33; Ga. L. 2009, p. 453, § 1-6/HB 228.)

The 2009 amendment, effective July 1, 2009, substituted "commissioner of community health" for "commissioner of human resources" at the end of subsection (a) and in paragraphs (b)(4) and (b)(5).

33-21-17. Examinations of organizations and providers; reports of examinations; payment of expenses of examinations.

(a) Whenever the Commissioner of Insurance shall deem it expedient, but not less than once every three years, he or his designee shall visit and examine the transactions, accounts, financial records, and documents of any health maintenance organization and of the providers with whom such organization has contracts, agreements, or other arrangements pursuant to its health benefits plan; and in connection with such examination the Commissioner of Insurance shall also have the authority to conduct an examination into the market conduct of the health maintenance organization.

(b) Whenever the commissioner of community health shall deem it expedient, but not less than once every five years, he or she or his or her designee shall visit and examine all matters relating to the quality of health care services of any health maintenance organization and providers with whom the organization has contracts, agreements, or other arrangements pursuant to its health benefits plan as often as he or she deems it necessary for the protection of the interests of the people of this state; provided, however, that health maintenance organizations meeting the requirements of subsection (b.1) of Code Section 33-21-3 shall not be subject to examination by the commissioner of community health.

(c) Every health maintenance organization, its officers, employees, representatives, and providers shall produce and make freely accessible to the Commissioner of Insurance or the commissioner of community health the accounts, records, documents, and files in its possession or control relating to the subject of the examination. The officers, employees, representatives, and providers shall facilitate such examination and aid the examiners as far as it is in their power in making the examination.

(d) The Commissioner of Insurance or his designee shall make a full written report of each examination made by him containing only facts ascertained from the accounts, records, and documents examined and from the sworn testimony of witness.

(e) The report shall be certified by the Commissioner of Insurance or by the examiner in charge of the examination and, when so certified and after filing as provided in subsection (f) of this Code section, shall be admissible in evidence in any proceeding brought by the Commissioner

against the health maintenance organization examined or any officer or agent of the health maintenance organization and shall be prima-facie evidence of the facts stated in such report.

(f) The Commissioner of Insurance shall furnish a copy of the proposed report to the health maintenance organization examined not less than 20 days prior to filing the report. If the health maintenance organization so requests in writing within such 20 day period or any longer period as the Commissioner may grant, the Commissioner shall grant a hearing with respect to the report and shall not file the report until after the hearing and such modifications have been made in the report as the Commissioner may deem proper.

(g) The Commissioner of Insurance may withhold from public inspection the report of any examination or investigation for so long as he deems it to be in the public interest or necessary to protect the health maintenance organization examined from unwarranted injury.

(h) After the report has been filed, the Commissioner of Insurance may publish the report or the results of such report in one or more newspapers published in this state if he should deem it to be in the public interest.

(i) The health maintenance organization so examined shall pay, at the direction of the Commissioner of Insurance, all the actual travel and living expenses connected with the examination. When the examination is made by an examiner who is not a regular employee of the Insurance Department, the health maintenance organization examined shall pay the proper charges for the services of the examiner and his assistants in an amount approved by the Commissioner. A consolidated account for the examination shall be filed by the examiner with the Commissioner. No health maintenance organization or other entity shall pay and no examiner shall accept any additional emolument on account of any examination. When the examination is conducted in whole or in part by regular salaried employees of the department, payment for the services and proper expenses shall be made by the health maintenance organization examined to the Commissioner; and such payment shall be deposited with the Office of the State Treasurer. (Code 1933, § 56-3616, enacted by Ga. L. 1979, p. 1148, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 1992, p. 6, § 33; Ga. L. 1993, p. 1402, § 18; Ga. L. 2004, p. 493, § 4; Ga. L. 2009, p. 453, § 1-6/HB 228; Ga. L. 2010, p. 863, § 2/SB 296.)

The 2004 amendment, effective May 13, 2004, in subsection (b), inserted "or she" twice, inserted "or her" near the beginning, and added the proviso at the end.

The 2009 amendment, effective July 1, 2009, substituted "commissioner of community health" for "commissioner of human resources" twice in subsection (b) and in the first sentence of subsection (c).

The 2010 amendment, effective July

1, 2010, substituted "Office of the State Treasurer" for "Office of Treasury and Fiscal Services" at the end of subsection (i).

33-21-18. Adoption of rules and regulations generally.

(a) The Commissioner of Insurance shall adopt rules and regulations necessary for the implementation of this chapter with respect to all matters of organization, control of the matters relating to business, agents, examinations, and all other Code sections not exempted by this Code section.

(b) The commissioner of community health shall adopt rules and regulations for health maintenance organizations subject to his or her jurisdiction which are not inconsistent with this chapter and which are necessary to establish and control the standards of health care which a health maintenance organization shall maintain. Health maintenance organizations meeting the requirements of subsection (b.1) of Code Section 33-21-3 shall not be subject to the jurisdiction of the commissioner of community health. (Code 1933, § 56-3619, enacted by Ga. L. 1979, p. 1148, § 1; Ga. L. 1992, p. 6, § 33; Ga. L. 2004, p. 493, § 5; Ga. L. 2009, p. 453, § 1-6/HB 228.)

The 2004 amendment, effective May 13, 2004, in subsection (b), inserted "for health maintenance organizations subject to his or her jurisdiction which are not inconsistent with this chapter and which are" near the beginning of the first sentence and added the second sentence.

The 2009 amendment, effective July 1, 2009, substituted "commissioner of community health" for "commissioner of human resources" in both sentences in subsection (b).

33-21-20. Conduct of hearings generally; participation in hearings by commissioner of community health; judicial review.

(a) Except as otherwise provided in this chapter, all hearings and proceedings held under this chapter shall be conducted in accordance with Chapter 2 of this title and the Commissioner of Insurance shall have all the powers granted to him in Chapter 2 of this title.

(b) The commissioner of community health, or his or her designated representative, shall be in attendance at the hearings and shall participate in the proceedings. The recommendation and findings of the commissioner of community health with respect to matters regarding health maintenance organizations under his or her jurisdiction relating to the quality of health care services provided in connection with any decision regarding denial, suspension, or revocation of a certificate of authority shall be conclusive and binding upon the Commissioner of Insurance. Health maintenance organizations meeting the require-

ments of subsection (b.1) of Code Section 33-21-3 shall not be subject to the jurisdiction of the commissioner of community health. After the hearing, or upon the failure of the health maintenance organization to appear at the hearing, the Commissioner of Insurance shall take action as is deemed advisable on written findings which shall be mailed to the health maintenance organization with a copy of the findings mailed to the commissioner of community health. The action of the Commissioner of Insurance and the recommendation and findings of the commissioner of community health shall be subject to review by the superior court having jurisdiction. The court may, in disposing of the issue before it, modify, affirm, or reverse the order of the Commissioner of Insurance in whole or in part.

(c) Chapter 13 of Title 50, the "Georgia Administrative Procedure Act," shall apply to proceedings under this Code section to the extent that they are not in conflict with subsections (a) and (b) of this Code section. (Code 1933, § 56-3620, enacted by Ga. L. 1979, p. 1148, § 1; Ga. L. 1992, p. 6, § 33; Ga. L. 2004, p. 493, § 6; Ga. L. 2009, p. 453, § 1-6/HB 228.)

The 2004 amendment, effective May 13, 2004, in subsection (b), inserted "or her" in the first sentence, inserted "regarding health maintenance organizations under his or her jurisdiction" in the middle of the second sentence, and added the third sentence.

The 2009 amendment, effective July 1, 2009, substituted "commissioner of community health" for "commissioner of human resources" throughout subsection (b).

33-21-20.1. Regulation of HMOs by commissioner of community health.

On May 13, 2004, all health maintenance organizations meeting the requirements of subsection (b.1) of Code Section 33-21-3 shall not be subject to regulation by the commissioner of human resources (now known as the commissioner of community health for these purposes). Upon the Commissioner of Insurance's determination that a health maintenance organization no longer meets the requirements of subsection (b.1) of Code Section 33-21-3, the Commissioner shall immediately notify the commissioner of community health; and such health maintenance organization shall be subject to regulation by the commissioner of community health until such time as it again meets the requirements of subsection (b.1) of Code Section 33-21-3 as determined by the Commissioner of Insurance. (Code 1981, § 33-21-20.1, enacted by Ga. L. 2004, p. 493, § 7; Ga. L. 2009, p. 453, § 1-40/HB 228.)

Effective date. — This Code section became effective May 13, 2004.

The 2009 amendment, effective July 1, 2009, inserted "(now known as the commissioner of community health for these purposes)" in the first sentence and,

in the last sentence, substituted "commissioner of community health" for "commissioner of human resources" twice.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2004, "On May 13, 2004," was substituted for "Upon the effective date of this Code section," at the beginning of the first sentence.

33-21-21. Authority of commissioner of community health to contract for making of recommendations required by chapter; acceptance of recommendations.

The commissioner of community health, in carrying out his obligations under subsection (b) of Code Section 33-21-3, paragraph (4) of subsection (a) of Code Section 33-21-5, and subsection (b) of Code Section 33-21-17, may contract with qualified persons to make recommendations concerning the determinations required to be made by him. Such recommendations may be accepted in full or in part by the commissioner of community health. (Code 1933, § 56-3626, enacted by Ga. L. 1979, p. 1148, § 1; Ga. L. 2009, p. 453, § 1-6/HB 228.)

The 2009 amendment, effective July 1, 2009, substituted "commissioner of community health" for "commissioner of human resources" in both sentences of this Code section.

33-21-27. Enforcement of chapter; penalties for violations of chapter.

(a)(1) In lieu of suspension or revocation of a certificate of authority for any of the causes enumerated in Code Section 33-21-5, the Commissioner of Insurance may place a health maintenance organization on probation or may fine the health maintenance organization in accordance with Chapter 2 of this title when, in his judgment, he finds that the public interest would not be harmed by the continued operation of the health maintenance organization. The amount of any penalty shall be paid by the health maintenance organization to the Commissioner for use by the state. At any hearing conducted in accordance with this title, the Commissioner shall have authority to administer oaths to witnesses. Anyone testifying falsely, after having been administered the oath, shall be subject to the penalty of perjury.

(2) Any action of the Commissioner of Insurance taken pursuant to this Code section shall be subject to such review as may be provided in Chapter 2 of this title.

(b)(1) If the Commissioner of Insurance or the commissioner of community health shall, for any reason, have cause to believe that any violation of this chapter has occurred or is threatened, the Commissioner of Insurance or the commissioner of community health may give notice to the health maintenance organization and to the representatives or other persons who appear to be involved in the suspected violation to arrange a conference with the alleged violators

or their authorized representatives for the purpose of attempting to ascertain the facts relating to the suspected violation and, in the event it appears that any violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing such violation.

(2) Proceedings under this subsection shall not be governed by any formal procedural requirements and may be conducted in such manner as the Commissioner of Insurance or the commissioner of community health may deem appropriate under the circumstances.

(c)(1) The Commissioner of Insurance may issue an order directing a health maintenance organization or a representative of a health maintenance organization to cease and desist from engaging in any act or practice in violation of this chapter.

(2) Within five days after service of the order of cease and desist, the respondent may request a hearing on the question of whether acts or practices in violation of this chapter have occurred. The hearings shall be conducted pursuant to Chapter 13 of Title 50, the "Georgia Administrative Procedure Act," and judicial review shall be available as provided in Chapter 13 of Title 50.

(d) In the case of any violation of this chapter, if the Commissioner of Insurance elects not to issue a cease and desist order or in the event of noncompliance with a cease and desist order issued pursuant to this Code section, the Commissioner may institute a proceeding to obtain injunctive relief, or seeking other appropriate relief, in the superior court having jurisdiction of the parties.

(e) In addition to any other liability or punishment prescribed, any person who violates this chapter shall be guilty of a misdemeanor. (Code 1933, § 56-3622, enacted by Ga. L. 1979, p. 1148, § 1; Ga. L. 1992, p. 6, § 33; Ga. L. 2009, p. 453, § 1-6/HB 228.)

The 2009 amendment, effective July 1, 2009, substituted "commissioner of community health" for "commissioner of human resources" in paragraph (b)(1) twice and in paragraph (b)(2).

33-21-28. Applicability of provisions of title and of other laws to health maintenance organizations and representatives.

JUDICIAL DECISIONS

Exhuastion of remedies. — Medical group's suit for a declaratory judgment as to the group's rights to participate in a health maintenance organization under Georgia's Any Willing Provider Statute, O.C.G.A. § 33-20-16, was procedurally barred by the failure to exhaust administrative remedies by first submitting the group's dispute to the Georgia Insurance Commissioner pursuant to O.C.G.A.

§ 33-20-30. Northeast Ga. Cancer Care, LLC v. Blue Cross & Blue Shield of Ga., Inc., 297 Ga. App. 28, 676 S.E.2d 428 (2009), cert. denied, No. S09C1241, 2009 Ga. LEXIS 805 (Ga. 2009).

CHAPTER 21A

MEDICAID CARE MANAGEMENT ORGANIZATIONS

Effective date. — This chapter became effective May 13, 2008.

33-21A-1. Short title.

This chapter shall be known and may be cited as the "Medicaid Care Management Organizations Act." (Code 1981, § 33-21A-1, enacted by Ga. L. 2008, p. 704, § 1/HB 1234.)

33-21A-2. Definitions.

As used in this chapter, the term:

(1) "Care management organization" means an entity that is organized for the purpose of providing or arranging health care, which has been granted a certificate of authority by the Commissioner of Insurance as a health maintenance organization pursuant to Chapter 21 of this title, and which has entered into a contract with the Department of Community Health to provide or arrange health care services on a prepaid, capitated basis to members.

(2) "Coordination of care" means early identification of members who have or may have special needs; assessment of a member's risk

factors; development of a plan of care; referrals and assistance to ensure timely access to providers; actively linking the member to providers, medical services, and residential, social, and other support services where needed; monitoring; continuity of care; and follow-up and documentation, all as further described pursuant to the terms of the contracts between the Department of Community Health and the care management organizations.

(3) "Critical access hospital" means a hospital that meets the requirements of the federal Centers for Medicare and Medicaid Services to be designated as a critical access hospital and that is recognized by the Department of Community Health as a critical access hospital for purposes of Medicaid.

(4) "Emergency health care services" means health care services that are provided for a condition of recent onset and sufficient severity, including, but not limited to, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in:

(A) Placing the patient's health in serious jeopardy;

(B) Serious impairment to bodily functions; or

(C) Serious dysfunction of any bodily organ or part.

(5) "Health care provider" or "provider" means any person, partnership, professional association, corporation, facility, or institution certified, licensed, or registered by the State of Georgia that has contracted with a care management organization to provide health care services to members.

(6) "Health care services" has the same meaning as in paragraph (5) of Code Section 33-21-1.

(7) "Health maintenance organization" means an entity which has been issued a certificate of authority by the Commissioner of Insurance pursuant to Chapter 21 of this title to establish and operate a health maintenance organization.

(8) "Hospital Statistical and Reimbursement Report" or "HS&R report" means a report created by a care management organization, using the same format that is used by the Department of Community Health in completing HS&R reports, that includes data related to an individual hospital, including aggregate statistics and reimbursement data for all Medicaid recipients who are covered by the care management organization and who received health care services at such hospital during a specific fiscal year, including data regarding

services that were provided out of network. HS&R reports are utilized by the Department of Community Health for purposes of the Indigent Care Trust Fund's disproportionate share hospital survey and are also utilized by hospitals to claim payments under medicare's disproportionate share hospital program.

(9) "Medicaid" means the joint federal and state program of medical assistance established by Title XIX of the federal Social Security Act, which is administered in this state by the Department of Community Health pursuant to Article 7 of Chapter 4 of Title 49.

(10) "Member" means a Medicaid or PeachCare for Kids recipient who is currently enrolled in a care management organization plan.

(11) "PeachCare for Kids" means the State of Georgia's State Children's Health Insurance Program established pursuant to Title XXI of the federal Social Security Act, which is administered in this state by the Department of Community Health pursuant to Article 13 of Chapter 5 of Title 49.

(12) "Post-stabilization services" means covered services related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition or to improve or resolve the member's condition.

(13) "Responsible health organization" means the entity that a health care provider reasonably identifies to be responsible for providing or arranging health care services for a patient who is a Medicaid or PeachCare for Kids recipient after the provider has properly conducted an eligibility verification in accordance with the procedures of the Department of Community Health. (Code 1981, § 33-21A-2, enacted by Ga. L. 2008, p. 704, § 1/HB 1234.)

33-21A-3. Certificate of authority required; setting of rates; authority of commissioners.

(a) A care management organization shall be required to obtain a certificate of authority as a health maintenance organization pursuant to Chapter 21 of this title prior to providing or arranging health care for members pursuant to a contract with the Department of Community Health. On and after the date of issuance of its certificate of authority as a health maintenance organization, a care management organization shall comply with all provisions relating to health maintenance organizations and all provisions relating to managed health care plans, with the exception of Code Section 33-20A-9.1.

(b) The Commissioner of Insurance shall not have the authority to approve, disapprove, or set rates paid by the Department of Community

Health to a care management organization or paid by a care management organization to a health care provider.

(c) The Commissioner of Insurance shall not have the authority to approve, disapprove, or modify any plan offered by a care management organization or any contract between a care management organization and the Department of Community Health.

(d) Nothing in this chapter shall be interpreted as altering the authority of the commissioner of community health. (Code 1981, § 33-21A-3, enacted by Ga. L. 2008, p. 704, § 1/HB 1234.)

33-21A-4. Reimbursement for emergency health care services.

(a) In particular, but without limitation, a care management organization shall not:

(1) Deny or inappropriately reduce payment to a provider of emergency health care services for any evaluation, diagnostic testing, or treatment provided to a recipient of medical assistance for an emergency condition; or

(2) Make payment for emergency health care services contingent on the recipient or provider of emergency health care services providing any notification, either before or after receiving emergency health care services.

(b) In processing claims for emergency health care services, a care management organization shall consider, at the time that a claim is submitted, at least the following criteria:

(1) The age of the patient;

(2) The time and day of the week the patient presented for services;

(3) The severity and nature of the presenting symptoms;

(4) The patient's initial and final diagnosis; and

(5) Any other criteria prescribed by the Department of Community Health, including criteria specific to patients under 18 years of age.

A care management organization shall configure or program its automated claims processing system to consider at least the conditions and criteria described in this subsection for claims presented for emergency health care services. The Department of Community Health may develop and publish in print or electronically a list of additional standards to be used by care management organizations to maximize the identification and accurate payment of claims for emergency health care services.

(c) If a provider that has not entered into a contract with a care management organization provides emergency health care services or post-stabilization services to that care management organization's member, the care management organization shall reimburse the noncontracted provider for such emergency health care services and post-stabilization services at a rate equal to the rate paid by the Department of Community Health for Medicaid claims that it reimburses directly. (Code 1981, § 33-21A-4, enacted by Ga. L. 2008, p. 704, § 1/HB 1234; Ga. L. 2010, p. 838, § 10/SB 388.)

The 2010 amendment, effective June 3, 2010, inserted "in print or electronically" in the last sentence of the concluding paragraph of subsection (b).

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2008, a misspelling of "symptoms" was corrected in paragraph (b)(3).

33-21A-5. Requirements relating to critical access hospitals.

(a) A critical access hospital must provide notice to a care management organization and the Department of Community Health of any alleged breaches in its contract by such care management organization.

(b) If a critical access hospital satisfies the requirement of subsection (a) of this Code section, and if the Department of Community Health concludes, after notice and hearing, that a care management organization has substantively and repeatedly breached a term of its contract with a critical access hospital, the department is authorized to require the care management organization to pay damages to the critical access hospital in an amount not to exceed three times the amount owed. Notwithstanding the foregoing, nothing in this Code section shall be interpreted to limit the authority of the Department of Community Health to establish additional penalties or fines against a care management organization for failure to comply with the contract between a care management organization and the Department of Community Health. (Code 1981, § 33-21A-5, enacted by Ga. L. 2008, p. 704, § 1/HB 1234.)

33-21A-6. Coverage for newborn infants until discharged from inpatient care.

(a) Each care management organization shall pay for health care services provided to a newborn infant who is born to a mother who is a member currently enrolled with that care management organization until such time as the newborn is finally discharged from all inpatient care to a home environment subject to approval by the federal Centers for Medicare and Medicaid Services. For a newborn infant whose mother is enrolled in a Medicaid program under which she receives Medicaid benefits directly from the Department of Community Health,

the Department of Community Health shall pay for health care services provided to the newborn until such time as the newborn is finally discharged from all inpatient care to a home environment.

(b) In the event a newborn is disenrolled from a care management organization and re-enrolled into the Medicaid fee-for-service program conducted directly by the Department of Community Health, the care management organization shall ensure the coordination of care for that child until the child has been appropriately discharged from the hospital and placed in an appropriate care setting. (Code 1981, § 33-21A-6, enacted by Ga. L. 2008, p. 704, § 1/HB 1234.)

33-21A-7. Bundling of provider complaints and appeals.

(a) In reviewing provider complaints or appeals related to denial of claims, a care management organization shall allow providers to consolidate complaints or appeals of multiple claims that involve the same or similar payment or coverage issues, regardless of the number of individual patients or payment claims included in the bundled complaint or appeal.

(b) Each care management organization shall allow a provider that has exhausted the care management organization's internal appeals process related to a denied or underpaid claim or group of claims bundled for appeal the option either to pursue the administrative review process described in subsection (e) of Code Section 49-4-153 or to select binding arbitration by a private arbitrator who is certified by a nationally recognized association that provides training and certification in alternative dispute resolution. If the care management organization and the provider are unable to agree on an association, the rules of the American Arbitration Association shall apply. The arbitrator shall have experience and expertise in the health care field and shall be selected according to the rules of his or her certifying association. Arbitration conducted pursuant to this Code section shall be binding on the parties. The arbitrator shall conduct a hearing and issue a final ruling within 90 days of being selected, unless the care management organization and the provider mutually agree to extend this deadline. All costs of arbitration, not including attorney's fees, shall be shared equally by the parties.

(c) For all claims that are initially denied or underpaid by a care management organization but eventually determined or agreed to have been owed by the care management organization to a provider of health care services, the care management organization shall pay, in addition to the amount determined to be owed, interest of 20 percent per annum, calculated from 15 days after the date the claim was submitted. A care management organization shall pay all interest required to be paid

under this provision or Code Section 33-24-59.5 automatically and simultaneously whenever payment is made for the claim giving rise to the interest payment. All interest payments shall be accurately identified on the associated remittance advice submitted by the care management organization to the provider. A care management organization shall not be responsible for the penalty described in this subsection if the health care provider submits a claim containing a material omission or inaccuracy in any of the data elements required for a complete standard health care claim form as prescribed under 45 C.F.R. Part 162 for electronic claims, a CMS Form 1500 for nonelectronic claims, or any claim prescribed by the Department of Community Health.

(d) Each care management organization shall maintain a website that allows providers to submit, process, edit, rebill, and adjudicate claims electronically. To the extent a provider has the capability, each care management organization shall submit payments to providers electronically and submit remittance advices to providers electronically within one business day of when payment is made. To the extent that any of these functions involve covered transactions under 45 C.F.R. Section 162.900, et seq., then those transactions also shall be conducted in accordance with applicable federal requirements.

(e) Each care management organization shall post on its website a searchable list of all providers with which the care management organization has contracted. At a minimum, this list shall be searchable by provider name, specialty, and location. At a minimum, the list shall be updated once each month.

(f) The Department of Community Health shall require each care management organization to utilize the same timeframes and deadlines for submission, processing, payment, denial, adjudication, and appeal of Medicaid claims as the timeframes and deadlines that the Department of Community Health uses on claims it pays directly.

(g) No care management organization shall, as a condition of contracting with a provider, require that provider to participate or accept other plans or products offered by the care management organization unrelated to providing care to members. Any care management organization which violates this prohibition shall be subject to a penalty of $1,000.00 per violation. Such penalty shall be collected by the Department of Community Health. A care management organization shall not reduce the funding available for members as a result of payment of such penalties.

(h) No health care provider shall, as a condition of contracting with a care management organization, require that a care management organization contract with or not contract with another health care provider. Any health care provider which violates this subsection shall

be subject to a penalty of $1,000.00 per violation. Such penalty shall be collected by the Department of Community Health. A health care provider shall not terminate an agreement with a care management organization as a result of payment of such penalties. (Code 1981, § 33-21A-7, enacted by Ga. L. 2008, p. 704, § 1/HB 1234.)

33-21A-8. Participation by dentists.

(a) Except as provided in subsection (b) of this Code section, no care management organization or agent of such care management organization shall deny any dentist from participating in the Medicaid and PeachCare for Kids dental program administered by such care management organization if:

(1) Such dentist has obtained a license to practice in this state and is an enrolled provider who has met all of the requirements of the Department of Community Health for participation in the Medicaid and PeachCare for Kids program; and

(2)(A) The licensed dentist will provide dental services to members pursuant to a state or federally funded educational loan forgiveness program that requires such services; provided, however, each care management organization shall be required to offer dentists wishing to participate through such loan forgiveness programs the same contract terms offered to other dentists in the service region who participate in the care management organization's Medicaid and PeachCare for Kids dental programs;

(B) The geographic area in which the dentist intends to practice has been designated as having a dental professional shortage as determined by the Department of Community Health, which may be based on the designation of the Health Resources and Services Administration of the United States Department of Health and Human Services; or

(C) Such care management organization fails to establish to the satisfaction of the Department of Community Health that a sufficient number of general dentists and specialists have contracted with the care management organization to provide covered dental services to members in the geographic region.

(b) A care management organization may decline to contract with a dentist who meets the requirements of subsection (a) of this Code section if such dentist has had his or her license to practice dentistry sanctioned in any manner or fails to meet the credentialing criteria established by the care management organization. Any dentist denied on this basis shall be entitled to a hearing before an administrative law judge as set forth in subsection (e) of Code Section 49-4-153.

(c) The Department of Community Health shall also provide a means for dentists to request an annual hearing to determine whether a condition described in subparagraph (B) or (C) of paragraph (2) of subsection (a) of this Code section exists. The department may compel the attendance of care management organizations or agents of care management organizations to attend such hearings. The department may request additional information as a result of the hearing, and it shall consider matters raised in the hearing when deciding whether a condition described in subparagraph (A) or (B) of paragraph (2) of subsection (a) of this Code section exists. (Code 1981, § 33-21A-8, enacted by Ga. L. 2008, p. 704, § 1/HB 1234.)

33-21A-9. Submission and payment of claims.

(a) If a provider submits a claim to a responsible health organization for services rendered within 72 hours after the provider verifies the eligibility of the patient with that responsible health organization, the responsible health organization shall reimburse the provider in an amount equal to the amount to which the provider would have been entitled if the patient had been enrolled as shown in the eligibility verification process. After resolving the provider's claim, if the responsible health organization made payment for a patient for whom it was not responsible, then the responsible health organization may pursue a cause of action against any person who was responsible for payment of the services at the time they were provided but may not recover any payment made to the provider.

(b) If a provider verifies the eligibility of a patient as set forth in subsection (a) of this Code section, and if a provider determines that a person other than the responsible health organization to which it has submitted a claim is responsible for Medicaid or PeachCare for Kids coverage of the patient at the time the service was rendered, the provider may submit the claim to the person that is responsible for Medicaid or PeachCare for Kids coverage and that person shall reimburse all medically necessary services, without application of any penalty for failure to file claims in a timely manner, for failure to obtain prior authorization, or for the provider not being a participating provider in the person's network, and the amount of reimbursement shall be that person's applicable rate for the service if the provider is under contract with that person or the rate paid by the Department of Community Health for the same type of claim that it pays directly if the provider is not under contract with that person. (Code 1981, § 33-21A-9, enacted by Ga. L. 2008, p. 704, § 1/HB 1234.)

33-21A-10. New and renewal agreements with care management organizations and health care providers.

(a) On and after May 13, 2008, the Department of Community Health shall include provisions in all new or renewal agreements with a care management organization, which require the care management organization to comply with all provisions of this chapter.

(b) On and after May 13, 2008, a care management organization shall not include any provisions in new or renewal agreements with providers entered into pursuant to the contract between the Department of Community Health and the care management organization, which are inconsistent with the provisions of this chapter. (Code 1981, § 33-21A-10, enacted by Ga. L. 2008, p. 704, § 1/HB 1234.)

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2008, paragraphs (1) and (2) were redesignated as subsections (a) and (b), respectively, and "May 13, 2008" was substituted for "the effective date of this chapter" in subsections (a) and (b).

33-21A-11. Hospital statistical and reimbursement reports from care management organizations; penalty.

Upon request by a hospital provider related to a specific fiscal year, a care management organization shall, within 30 days of the request, provide that hospital with an HS&R report for the requested fiscal year. Any care management organization which violates this Code section by not providing the requested report within 30 days shall be subject to a penalty of $1,000.00 per day, starting on the thirty-first day after the request and continuing until the report is provided. It is the intent of the General Assembly that such penalty be collected by the Department of Community Health and deposited into the Indigent Care Trust Fund created pursuant to Code Section 31-8-152. A care management organization shall not reduce the funding available for health care services for members as a result of payment of such penalties. (Code 1981, § 33-21A-11, enacted by Ga. L. 2008, p. 704, § 1/HB 1234.)

33-21A-12. Federal law, rule and regulations control.

To the extent any provision in this chapter is inconsistent with applicable federal law, rule, or regulation, the applicable federal law, rule, or regulation shall govern. (Code 1981, § 33-21A-12, enacted by Ga. L. 2008, p. 704, § 1/HB 1234.)

CHAPTER 22

INSURANCE PREMIUM FINANCE COMPANIES

33-22-3. Requirement of license for transaction of business; fees; change of address; examination of applicants.

(a) No person shall engage in the business of financing insurance premiums in this state without first having obtained a license as a premium finance company from the Commissioner.

(b) The annual license fee shall be as provided in Code Section 33-8-1. Licenses may be renewed from year to year as of March 1 of each year upon payment of the fee as provided in Code Section 33-8-1. The fee for said license shall be paid to the Commissioner for use by the state.

(c) Before any licensee changes his or her address, he or she shall inform the Commissioner of the change in writing.

(d) Subject to the penalties of perjury, the person to whom the license or the renewal of the license may be issued shall file sworn answers to such interrogatories as the Commissioner may require. The Commissioner shall have authority at any time to require the applicant fully to disclose the identity of all stockholders, partners, officers, and employees, and he may in his discretion refuse to issue or renew a license in the name of any firm, partnership, or corporation if he is not satisfied that any officer, employee, stockholder, or partner thereof who may materially influence the applicant's conduct meets the standards of this chapter.

(e) Any person who shall engage in the business of financing insurance premiums in this state without obtaining a license as provided in this Code section shall, upon conviction, be subject to a fine of not more

than $1,000.00. (Ga. L. 1969, p. 561, § 4; Ga. L. 1975, p. 1234, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 1992, p. 2725, § 21; Ga. L. 2002, p. 1192, § 2.)

The 2002 amendment, effective July 1, 2002, substituted the present provisions of subsection (c) for the former provisions, which read: "Before any licensee changes his address he shall return his license to the Commissioner who shall endorse the license indicating the change."

33-22-7. Maintenance of records of transactions by licensees; examination of records by Commissioner.

(a) Every licensee shall maintain records of its premium finance transactions and the said records shall be open to examination and investigation by the Commissioner.

(b) Every licensee shall preserve its records of its premium finance transactions, including cards used in a card system, for at least three years after making the final entry in respect to any premium finance agreement. The preservation of records in photographic or electronic form shall constitute compliance with this requirement.

(c) The Commissioner may at any time require any licensee to bring such records as he may direct to the Commissioner's office for examination or, if he deems it necessary, the Commissioner or his duly authorized representative may conduct an examination of the records on the premises of the licensee. The expense of any on-the-premise examination shall be borne by the licensee, as provided in the case of examinations of insurers conducted pursuant to Code Section 33-2-15. (Ga. L. 1969, p. 561, § 7; Ga. L. 1975, p. 1234, § 4; Ga. L. 1980, p. 505, § 2; Ga. L. 2002, p. 1192, § 3.)

The 2002 amendment, effective July 1, 2002, inserted "or electronic" in the second sentence in subsection (b).

33-22-8. Form, contents, execution, and delivery of premium finance agreement; financing of additional premiums.

(a) A premium finance agreement shall:

(1) Be dated and signed by or on behalf of the insured, and the printed portion of the agreement shall be in approximately eight-point type and shall be readable by an individual with average eyesight;

(2) Contain the name and place of business of the insurance agent or insurance broker negotiating the related insurance contract, the name and residence or place of business of the insured as specified by him or her, the name and place of business of the premium finance company to which payments are to be made, a description of the

insurance contracts involved, and the amount of the premium for the contracts; and

(3) Set forth the following items, where applicable:

(A) The total amount of the premiums;

(B) The amount of the down payment;

(C) The principal balance (the difference between subparagraphs (A) and (B) of this paragraph);

(D) The amount of the service charge, including the additional charge as provided in Code Section 33-22-9;

(E) The balance payable by the insured (the sum of subparagraphs (C) and (D) of this paragraph); and

(F) The number of payments required, the amount of each payment expressed in dollars, and the due date or period of payment.

(b) The items set out in paragraph (3) of subsection (a) of this Code section need not be stated in the sequence or order in which they appear in such paragraph, and additional items may be included to explain the computations made in determining the amount to be paid by the insured.

(c) The licensee or the insurance agent or insurance broker shall deliver to the insured or send by electronic means or mail to the insured at his or her address shown in the agreement a complete copy of the agreement.

(d) Whenever an insurance policy has been financed pursuant to this chapter, an additional premium to such policy or a renewal or extension of such policy may be financed with the same premium finance company without the execution of a new premium finance agreement. The premium finance company or the insurance agent or insurance broker shall deliver to the insured or send by electronic means or mail to the insured at his or her address shown in the agreement an addendum to the existing premium finance agreement, and such addendum shall contain the information required under subsection (a) of this Code section. (Ga. L. 1969, p. 561, § 9; Ga. L. 1970, p. 567, § 1; Ga. L. 1981, p. 760, § 1; Ga. L. 1995, p. 1047, § 1; Ga. L. 2002, p. 1192, § 4.)

The 2002 amendment, effective July 1, 2002, in subsection (a), substituted "approximately" for "at least" and added "and shall be readable by an individual with average eyesight" in paragraph (1), and substituted "or place of business" for "of place of business" in paragraph (2); inserted "or send by electronic means" in subsection (c); and, in subsection (d), substituted the current provisions of the last sentence for the former provisions, which read: "The premium finance company shall mail or deliver to the insured an addendum to the existing premium fi-

nance agreement in the same manner as provided in subsection (c) of this Code section, and such addendum shall contain the information required under subsection (a) of this Code section."

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2002, "paragraph" was substituted for "clause" in subsection (b).

33-22-9. Service charges.

(a) As used in this Code section, the term:

(1) "Commercial insurance premium finance agreement" means any insurance premium finance agreement other than a consumer premium finance agreement.

(2) "Consumer insurance premium finance agreement" means an insurance premium finance agreement, as defined in Code Section 33-22-2, wherein the insurance contracts which are the subject of the premium finance agreement are for personal, family, or household purposes rather than business or professional purposes.

(b) A premium finance company shall not charge, contract for, receive, or collect a service charge other than as permitted by this chapter.

(c) The service charge shall be computed on the balance of the premiums due, after subtracting the down payment made by the insured in accordance with the premium finance agreement, from the effective date of the insurance coverage for which the premiums are being advanced, to and including the date when the final payment of the premium finance agreement is payable; provided, however, that service charges as specified in the premium finance agreement may continue to be charged until such agreement is paid in full.

(d) The service charge per consumer insurance premium finance agreement shall be a maximum of $12.00 per $100.00 per annum plus an additional charge which shall not exceed $20.00 per premium finance agreement, which additional charge need not be refunded upon prepayment. Any insured may prepay his or her premium finance agreement in full at any time before the due date of the final payment and in such event the unearned service charge shall be refunded in accordance with the Rule of 78 and shall represent at least as great a proportion of the service charge, if any, as the sum of the periodic balances after the month in which prepayment is made bears to the sum of all periodic balances under the schedule of payments in the agreement.

(e) The service charge for a commercial insurance premium finance agreement shall be properly agreed upon by the parties to the contract. The claim or defense of usury by such insureds who enter into such a commercial insurance premium finance agreement or their successors

or anyone in their behalf shall not be valid if such agreement is a valid contract in all other respects. (Ga. L. 1969, p. 561, § 10; Ga. L. 1970, p. 567, § 2; Ga. L. 1979, p. 1076, § 1; Ga. L. 1981, p. 760, § 2; Ga. L. 2002, p. 1192, § 5; Ga. L. 2003, p. 140, § 33.)

The 2002 amendment, effective July 1, 2002, substituted "rather than business or professional purposes" for "or where the premiums for those agreements are $3,000.00 or less" in paragraph (a)(2), and added the proviso at the end of subsection (c).

The 2003 amendment, effective May 14, 2003, part of an Act to revise, modernize, and correct the Code, substituted "his or her premium" for "his premium" in the second sentence of subsection (d).

33-22-12.1. Notice to insured by premium finance company; copy of premium finance agreement; notice of existence of power of attorney.

Whenever a premium finance company executes a premium finance agreement relative to a personal or family-type policy of insurance, it shall deliver to the insured or send by electronic means or mail to the insured at his or her address shown in the agreement a copy of the agreement and a written notice which clearly discloses to the insured the existence of the power of attorney contained in such agreement. The written notice shall substantially comply with the following form:

"NOTICE

Your insurance policy premiums have been financed and are payable on a monthly payment basis. If you do not pay each payment on or before the date due or within 15 days of the date due, we have the right to CANCEL your insurance policy or policies which are financed under the premium finance agreement. To avoid cancellation of your policy or policies, MAKE YOUR PAYMENTS ON TIME."

(Code 1981, § 33-22-12.1, enacted by Ga. L. 1995, p. 1047, § 3; Ga. L. 2002, p. 1192, § 6.)

The 2002 amendment, effective July 1, 2002, in the introductory paragraph, substituted "deliver to the insured or send by electronic means or mail to the insured at his or her address shown in the agreement" for "mail or deliver to the insured" and deleted "as provided in subsection (c) of Code Section 33-22-8" following "a copy of the agreement".

33-22-13. Procedure for cancellation of insurance contract upon default.

(a) When a premium finance agreement contains a power of attorney enabling the premium finance company to cancel any insurance contract or contracts listed in the agreement, the insurance contract or

contracts shall not be canceled by the premium finance company unless the cancellation is effectuated in accordance with this Code section.

(b) Not less than ten days' written notice shall be delivered to the insured or sent by electronic means or mailed to the insured at his or her address shown in the agreement of the intent of the premium finance company to cancel the insurance contract unless the default is cured within such ten-day period. A copy of said notice shall also be sent to the insurance agent or insurance broker indicated on the premium finance agreement.

(c)(1) After expiration of such ten-day period, the premium finance company may thereafter in the name of the insured cancel such insurance contract or contracts by mailing or delivering to the insurer a notice of cancellation; and the insurance contract shall be canceled as if the notice of cancellation had been submitted by the insured, but without requiring the return of the insurance contract or contracts. The premium finance company, when mailing or delivering notice to the insurance company to cancel the policy, shall mail notice to the insured notifying him or her of the action taken. Such notice to the insured shall contain the date and time the policy is to be canceled, which date shall be after the date of mailing of such notice, and shall inform the insured that any payment received after the mailing or delivery of notice to the insurance company to cancel the policy will not reinstate the policy. The notice may contain information to the effect that the premium finance company will make a request to the insurance company to reinstate the policy. Language sufficiently clear and specific so that a person of average intelligence can understand the action being taken by the premium finance company shall be used. The notice to the insured required by this subsection shall be mailed to the last address of record of the insured and shall be dispatched by at least first-class mail and receiving the receipt provided by the United States Postal Service or such other evidence of mailing as prescribed or accepted by the United States Postal Service.

(2) The receipt of the notice of cancellation provided in paragraph (1) of this subsection by the insurer shall create a conclusive presumption that the premium finance company has fully complied with all the requirements of this Code section, that the insurer is entitled to rely on such presumption, and that the cancellation of the insurance contract or contracts is concurred in and authorized by the insured. No liability of any nature whatsoever shall be imposed upon the insurer as a result of the failure by the insured to receive the notice of the action taken required by paragraph (1) of this subsection or as a result of the failure of the insurance premium finance company to comply with any of the requirements of this Code section.

(d) All statutory, regulatory, and contractual restrictions providing that the insurance contract may not be canceled unless notice is given to a governmental agency, mortgagee, or other third party shall apply where cancellation is effected under this Code section. The insurer shall give the prescribed notice on behalf of itself or the insured to any governmental agency, mortgagee, or other third party on or before the second business day after the day it receives the notice of cancellation from the premium finance company and shall determine the effective date of cancellation taking into consideration the number of days required to complete the cancellation. (Ga. L. 1969, p. 561, § 12; Ga. L. 1984, p. 1345, § 2; Ga. L. 1985, p. 149, § 33; Ga. L. 1986, p. 496, § 1; Ga. L. 1995, p. 1047, § 4; Ga. L. 2002, p. 1192, § 7.)

The 2002 amendment, effective July 1, 2002, substituted "delivered to the insured or sent by electronic means or mailed to the insured at his or her address shown in the agreement" for "mailed to the insured" in the first sentence in subsection (b).

JUDICIAL DECISIONS

Notice requirements.

Premium finance company's notice to an insured, pursuant to O.C.G.A. § 33-22-13(b), that the policy would be cancelled for nonpayment of premiums was effective because the check the insured sent to pay the premium had been returned for insufficient funds. Kolencik v. Stratford Ins. Co., No. 1:05-cv-0007-GET, 2005 U.S. Dist. LEXIS 34956 (N.D. Ga. Nov. 28, 2005).

33-22-14. Disposition of unearned premiums upon cancellation of insurance policy.

(a) Whenever an insurance policy is canceled and the premiums have been paid by an insurance premium finance company on behalf of the insured, if the insurer has been notified of the existence of the insurance premium finance agreement as required in Code Section 33-22-12, the insurer shall return whatever unearned premiums are due to the insurance premium finance company for the account of the insured. Whenever an insurer, after receiving notification of the existence of the insurance premium finance agreement, returns any unearned premium to anyone other than the insurance premium finance company named in the agreement, the insurer shall be directly responsible to such insurance premium finance company for any and all unearned premiums due as a result of the cancellation. The insurer shall furnish to the agent, agency, or broker placing the insurance a report setting forth an itemization of the unearned premiums under the policy.

(b)(1) In the event that the crediting of return premiums to the account of the insured results in a surplus over the amount due from the insured, the premium finance company shall refund the excess

within ten working days of receipt of the return premium or tender of return premium to the insured via the agent, agency, or broker placing the insurance and shall furnish such agent, agency, or broker, upon a written request, a report setting forth an itemization of the unearned finance charge and other charges under the premium finance agreement; provided, however, there shall be no refund required when the excess due the insured is less than $5.00.

(2) Any insurance premium finance company failing to tender refunds or to furnish any report requested by the agent, agency, or broker as required in paragraph (1) of this subsection shall pay to the insured via the agent, agency, or broker a penalty equal to 25 percent of the amount of the refund and interest equal to 18 percent per annum until such time as the refund is made; provided, however, the maximum amount of such penalty and interest shall not exceed 50 percent of the amount of the refund due.

(3) Upon receipt of the refund from the insurance premium finance company, the agent, agency, or broker shall return any unearned premiums to the insured either in person or by depositing such refund in the mail within ten working days of receipt of the refund.

(4) Any agent, agency, or broker failing to tender any unearned premium as prescribed in paragraph (3) of this subsection shall be subject to the penalties prescribed in paragraph (3) of subsection (c) of Code Section 33-24-44.

(c) Failure to refund any surplus or return any unearned premium or to furnish any reports requested by the agent, agency, or broker under subsection (b) of this Code section shall not invalidate a notice of cancellation given in accordance with this chapter. (Ga. L. 1969, p. 561, § 13; Ga. L. 1971, p. 324, § 1; Ga. L. 1976, p. 1564, § 1; Ga. L. 1984, p. 1345, § 3; Ga. L. 1985, p. 149, § 33; Ga. L. 2002, p. 1192, § 8.)

The 2002 amendment, effective July 1, 2002, substituted "$5.00" for "$2.00" at the end of paragraph (b)(1).

33-22-14.1. Transmissions of electronic records subject to provisions of Uniform Electronic Transactions Act.

Any use or transmission of electronic records or electronic signatures for purposes of this chapter shall be subject to the provisions of Chapter 12 of Title 10, the "Uniform Electronic Transactions Act." (Code 1981, § 33-22-14.1, enacted by Ga. L. 2002, p. 1192, § 9; Ga. L. 2009, p. 698, § 2/HB 126.)

Effective date. — This Code section became effective July 1, 2002.

The 2009 amendment, effective July 1, 2009, substituted "Uniform Electronic

Transactions Act" for "Georgia Electronic Records and Signatures Act" at the end of this Code section.

33-22-16. Applicability of chapter.

This chapter shall not apply with respect to:

(1) Any insurance company authorized to do business in this state;

(2) Any bank, trust company, savings and loan association, credit union, or other lending institution authorized to transact business in this state that does not possess or acquire any right, title, or interest with respect to the insurance policy for which the premiums are financed other than in the proceeds of the insurance policy in the event of loss;

(3) The inclusion of a charge for insurance in connection with an installment sale in accordance with Article 1 of Chapter 1 of Title 10;

(4) The financing of insurance premiums in this state in accordance with Article 1 of Chapter 4 of Title 7 relating to rates of interest;

(5) Insurance premiums in connection with the kinds of business defined in Code Sections 33-7-4 (life insurance) and 33-7-2 (accident and sickness insurance) and for those persons licensed under Chapter 3 of Title 7 to write the insurance authorized in Chapter 3 of Title 7;

(6) Any insurance agent or agency as defined in Code Section 33-23-1 who only finances premiums on policies written by or through such agent or agency, unless such agent or agency wishes to charge, contract for, receive, or collect the service charges, delinquency charges, and other fees or charges permitted under this chapter; in which event such agent or agency shall be required to comply with all of the provisions of this chapter except for the provisions of paragraph (4) of subsection (b) of Code Section 33-22-4, relating to the necessity of showing convenience or advantage to the community in order to obtain a license; or

(7) A holder in due course of the receivables generated by a premium finance company but who is not otherwise acting as a premium finance company under the provisions of this chapter. (Ga. L. 1969, p. 561, § 2; Ga. L. 1982, p. 1054, § 1; Ga. L. 1985, p. 1087, § 3; Ga. L. 2000, p. 136, § 33; Ga. L. 2002, p. 1192, § 10.)

The 2002 amendment, effective July 1, 2002, deleted "or" at the end of paragraph (5), substituted "; or" for a period at the end of paragraph (6), and added paragraph (7).